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Do Albanian Mental Health Services Meet Human Rights Standards? A Critical Application of the World Health Organization QualityRights Toolkit at Albania's Psychiatric Hospitals

Loli-Dano, Laura

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Laura Loli-Dano

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Doctor in Health

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CANDIDATE DECLARATIONS

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DECLARATION OF AUTHORSHIP

I am the author of this thesis, and the work described therein was carried out by myself personally, with the exception of the fieldwork where 1% of the data collection work was co-carried out by 3 members of the visiting committee.

Laura Loli-Dano

DECLARATION OF ANY PREVIOUS SUBMISSION OF THE WORK

The material presented here for examination for the award of a higher degree by research has not been incorporated into a submission for another degree.

Laura Loli-Dano

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To my son, Hermes

for his love, fun and beautiful personality

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ABSTRACT

Albanians endured 45 years of the rigid Hoxha Communist regime characterized by extreme poverty and violation of human rights (Muzeu i Memories, 2014; Amy, 2017). The extent to which human rights have improved in post-Communist Albania for people with mental disorders in psychiatric units, remains unknown.

In order to explore the protection of service users' human rights in Psychiatric Inpatient Units at the "Ali Mihali" Psychiatric Hospital in Vlora city and "Sadik Dinci" Psychiatric Hospital in Elbasan city, Albania's largest psychiatric hospitals, (Demi and Voko, 2014), this study used an evaluative mixed-methods triangulation study design with an in-between method of triangulation (Creswell, 1994; 2014). The study utilized the World Health Organization (WHO) QualityRights Toolkit (WHO, 2012b), based on the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2007) to gather qualitative semi-structured one-on-one interviews, qualitative observations and reviews of records and relevant policies/guidelines. Study findings were compared against the Surgery Inpatient Units, in Vlora and Elbasan General Hospitals because of the underlining assumption of difference in quality of care and human rights protection between psychiatric settings and general health settings (WHO, 2012b).

This study reported violation of negative rights/first generation rights and positive/second generation rights at the psychiatric hospitals. Lack of funding, staff stigma and lack of staff understanding of service user human rights emerged as key qualitative themes which negatively impact service user human rights in both Psychiatric Units. The presence of corruption was reported to negatively impact human rights of service users in the comparative Surgery Units at both General Hospitals.

For the WHO QualityRights Toolkit to serve as a policy solution regarding quality of care and human rights protection in health care, its application warrants serious consideration of the complex socio-economic and political landscape human rights are asserted in.

LIST OF ABBREVIATIONS

CRPD	Convention on the Rights of Persons with Disabilities
DALY	Disability Adjusted Life Years
EU	European Union
GBD	Global Burden of Disease
INSTAT	Institute of Statistics and Informatics of Albania
SIDA	Swedish International Development Corporation Agency
UN	United Nations
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization

CHAPTER I: INTRODUCTION

This chapter will provide a brief overview of the historical context of human rights and mental health developments in pre and post-Communist Albania. A snapshot of developments in these areas at an international level will follow. Study aim and research questions, in addition to the chapter outline, are subsequently presented.

SECTION 1: HISTORICAL CONTEXT

1.1: MENTAL HEALTH AND HUMAN RIGHTS IN PRE AND POST-COMMUNIST ALBANIA

Albania is situated in the Western Balkans with an approximate area of 29,000 square kilometres (Institute of Public Health, 2014) and an average population of 2.9 million people (Institute of Statistics and Informatics of Albania [INSTAT], 2018). Albanians endured 45 years of the rigid Hoxha Communist regime which was characterized by extreme poverty (Hardison, 1996; Schmidt; 1998) and violation of human rights (Muzeu i Memories, 2014; Amy, 2017). Stigma towards people with mental disorders and their human rights violations were predominant (World Health Organization [WHO], 2011). The Communist regime rejected the notion of mental illness as it contradicted the aspirations of the "Soviet man", similar to Eastern European countries (Tomov, 2007). Mental institutions were used to detain and persecute political dissidents (National Museum of Albania, 2017) in poorly funded and medically oriented (Suli et al. 2004; WHO, 2005b) state controlled services (Marku, 2010; Vian, 2011).

After the collapse of Communism in 1991, Albania moved towards establishing a free-market democracy as well as attempting to rapidly re-integrate into the international and European communities (World Bank, 2014), by developing acts which sanctioned human rights formally and legally (Kuvendi Populllor, 2003). Legislative developments in Health Care as well as Mental Health (Ministria e Shendetesise e Shqiperise, 2013)**,** were brought forward. Albania's commitment to protecting and promoting the rights of people with disabilities, including people with mental illnesses, led to the ratification of the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) in 2013 (UN, 2016).

Overall, the fall of Communism in Albania has generated economic growth and an improvement of human rights, such as democratic elections and freedom of speech (World Bank, 2014). The extent to which such improvements have been translated into an improvement of human rights for people with mental disorders in psychiatric units, remains unknown. This warranted the need for this study to take place.

1.2: HUMAN RIGHTS IN MENTAL HEALTH: GLOBAL DEVELOPMENTS

Internationally, developments in the mental health field have largely been influenced by the movement from institutional care to quality community-based care for people with mental disorders to ensure that they are considered equal citizens (WHO, 2001a). In health facilities, staff stigma perpetuates discrimination which is a human right issue, and consequently compromises the quality of care offered, with a direct impact on service user recovery, health and quality of life (WHO, 2012b; Jacob, 2001; Ritsher and Phelan, 2004). The UN CRPD launched in 2006 (UN, 2007) consolidates rights stated in other prior treaties and forms the basis for human rights standards that each service providing facility must respect, protect and fulfil (WHO, 2012b). The CRPD sees disability as a form of oppression. The WHO QualityRights Toolkit launched in 2012, based on the CRPD, encapsulated these rights into standards in order to ensure optimal protection of patient human rights (WHO, 2012b). Violations of these rights often occur (Kleinman, 2009) behind “closed or open doors” and go unreported and consequently unprevented (Hathaway, 2002; Murdie, 2009).

The ToolKit has been utilized in Afghanistan (Parwiz, 2015), Egypt (Fawzy, 2015), Somalia (Currie, 2012), Greece (Nomidou, 2012), Spain (Moreno, 2010), and Tunisia (Rekhis, 2015). The results of these studies have shown violation of service user human rights across all human rights categories of the Toolkit, which is consistent with historical data that segregation of people with mental disorders and other disabilities in large social care and/or psychiatric institutions has been occurring in most countries across the world (Wing and Brown, 1970; Desjarlais et al, 1995; Thornicroft and Tansella, 1999; 2004).

The literature review explores developments in the area of mental health with a focus on the protection of human rights in this field at an international level, and specifically within the Albanian context.

SECTION 2: STUDY AIM AND CHAPTER OUTLINE

The aim of this study is to explore the quality of care and consequently the state of human rights of people with mental disorders in Psychiatric Inpatient Units, at the 'Ali Mihali' Vlora Psychiatric Hospital and the 'Sadik Dinci' Elbasan Psychiatric Hospital, Albania's largest psychiatric hospitals (Demi and Voko, 2014).

The study's key questions are as follows:

- Do the Albanian Psychiatric Inpatient Units at the 'Ali Mihali' Vlora Psychiatric Hospital and the 'Sadik Dinci' Elbasan Psychiatric Hospital meet Human Rights standards?

- To what extent does the WHO QualityRights Toolkit accurately measure human rights protection within the Albanian perspective?

This study used an evaluative mixed-methods triangulation study design with an in-between method of triangulation (Creswell, 1994; 2014). The study utilized for the first time the standards of the WHO QualityRights Toolkit (WHO, 2012b) to gather qualitative semi-structured one-on-one interviews, qualitative observations and records and reviews of relevant policies/guidelines as key components which shaped this research and its final outcomes. Thematic analysis was used to analyse the voluminous qualitative feedback (Bryman and Burgess, 1994) gathered in this study. Study findings were compared against the Surgery Inpatient Units at Vlora General Hospital and Elbasan General Hospital because of the underlying assumption of a difference in quality of care and human rights protection between psychiatric settings and general health settings (WHO, 2012b).

The study is based on use of the WHO QualityRights Toolkit for which I received training by WHO in 2015. I designed the study, organized the assessment committee and trained its members. I organized the fieldwork and conducted the data collection process, together with the assessment committee members, and finalized the QualityRights Toolkit standards/themes ratings based on the committee members input and consensus.

The extent to which the WHO QualityRights Toolkit (WHO, 2012b) serves as a policy solution for the issue of protecting the human rights of people with mental illness in a country where Oriental views meet Western views (Sawicka, 2013) is yet to be discovered. A critical analysis of the QualityRights Toolkit to determine its validity and reliability within the Albanian context was conducted. Exploring the state of protection and promotion of human rights of service users with mental disorders in Albanian Psychiatric Inpatient Units will hopefully provide future directions regarding patient human rights' promotion and enhanced access to quality care in Albanian hospitals, as well as across other mental health facilities in this developing country.

To address the study's key questions, this thesis is comprised of 6 subsequent Chapters which are as follows:

Chapter II aims to present an overview of the mental health services in Albania under Communism and changes in these services after the collapse of Communism; developments in the mental health field in Albania with respect to the human rights of people with mental disorders will also be considered. Chapter III provides an overview of the prevalence of human rights violations amongst people with disabilities; the launch of the UN CRPD and subsequent to the latter, the WHO QualityRights Toolkit as an instrument which aims to assess the protection of the human rights of services users with mental disorders (WHO, 2012b). In addition, this chapter provides a summary of varying human rights as embedded in international acts and relevant conventions. Chapter IV provides a detailed overview of the methodology, design and procedures used in conducting this study. It refers to the conceptual framework informing this study as well as paving the way for justifying the use of and critiquing the WHO QualityRights Toolkit. Chapter V presents the data analysis and key findings from the data collection process of all 4 study hospitals. It presents a comparative summary of data collected at the study psychiatric hospitals against the study surgery units for the purpose of highlighting any quality of care differences and subsequently any differences in protection of human rights between psychiatric and general hospital surgery units. Chapter VI discusses key findings as they pertain to the objectives and research questions of this study. Recommendations are made regarding next steps based on study findings. Chapter VII refers to the critique of the WHO QualityRights Toolkit within the context of Albania and factors which impact the Toolkit's applicability within the Albanian context. Chapter VIII presents a summary of study contributions and future directions.

To conclude, this chapter provided a brief overview of the historical context in Albania which led to the rationale for conducting this study. It also provided a snapshot of key developments in human rights in mental health at a global level. The next chapter refers in details to human rights and mental health intersections in Albania.

CHAPTER II: HUMAN RIGHTS AND MENTAL HEALTH AND THEIR INTERSECTIONS IN ALBANIA

This chapter aims to present an overview of the mental health services in Albania under Communism, Albania's transition post the 1990s through the collapse of Communism in the country; developments in the mental health field in Albania with respect to the human rights of people with mental disorders will also be considered. It draws from an examination of primary and secondary document sources, including: systematic reviews of Albanian laws relevant to patient human rights, the Albanian constitution, country reports, systematic reviews, Albanian Health Care Policy and Mental Health Policy along with peer-reviewed articles. Last, research and media findings are critically analysed and reviewed.

SECTION 1: ALBANIA: HUMAN RIGHTS AND MENTAL HEALTH, WHERE THE PAST MEETS THE PRESENT

1.1: OVERVIEW OF THE ALBANIAN MENTAL HEALTH SYSTEM UNDER COMMUNISM

Until 1990, Albania's history was marked by 45 years of governance by the rigid Hoxha communist regime (Muzeu i Memories, 2014), which led to Albania being one of the poorest countries in Europe with a level of development similar to African and Latin American countries (World Bank, 2000). Under the Hoxha regime, the health care system in Albania was centralized and offered universal free coverage to all citizens (Marku, 2010). The Albanian health system embodied the Semashko system principles whereby the state exclusively owned all public healthcare institutions, which at the time of the communist system collapse were poorly run, outdated and overstaffed with underpaid staff (Marku, 2010; Tomini et al., 2015).

It is of particular importance to state that Communist control resulted in: ideological reluctance to accept mental illness as it contradicted the aspirations of the "Soviet man", similar to Eastern European countries (Tomov, 2007); the use of mental institutions to detain and persecute political dissidents (National Museum of Albania, 2017); inefficient and unresponsive state controlled services (WHO, 2003; Marku, 2010); lack of funding and other resources with a direct impact on quality of care (Lund and Fisher, 2003; WHO, 2003; Vian et al., 2006).

Historically, Albania's mental health services delivered care that was largely biologically/medically oriented and symptom focused (Suli, Lazeri and Nano, 2004; WHO, 2005b). The quality of mental health care was particularly poor (WHO, 2005b), with heavy reliance on the state (Marku, 2010) and very limited exposure to Western mental health care (Weinstein et al., 2000). Psychological treatments in the communist Albania involved 'work therapy', a concept rooted in Marxist philosophy (Simons, 1994) with an emphasis on volunteer work/ergo therapy to correct deviant behaviours.

During the communist system, serious infringements of the human rights of people with mental illnesses in Albania were identified (WHO, 2005b). Some of its features are illustrated in Figures 1, 2, 3, 5, 6 and 7. Similar to what occurred in Eastern and Central European countries, political dissidents were punitively declared mentally ill and incarcerated in psychiatric hospitals (National Museum of Albania, 2017). This is captured in Figure 4 which shows a number of named individuals who were considered to be dissidents and detained in a psychiatric hospital.

Figure 1: Elbasan Psychiatric Hospital in 1991 (Nikos Economopoulos\Magnum Photos, 1991a)

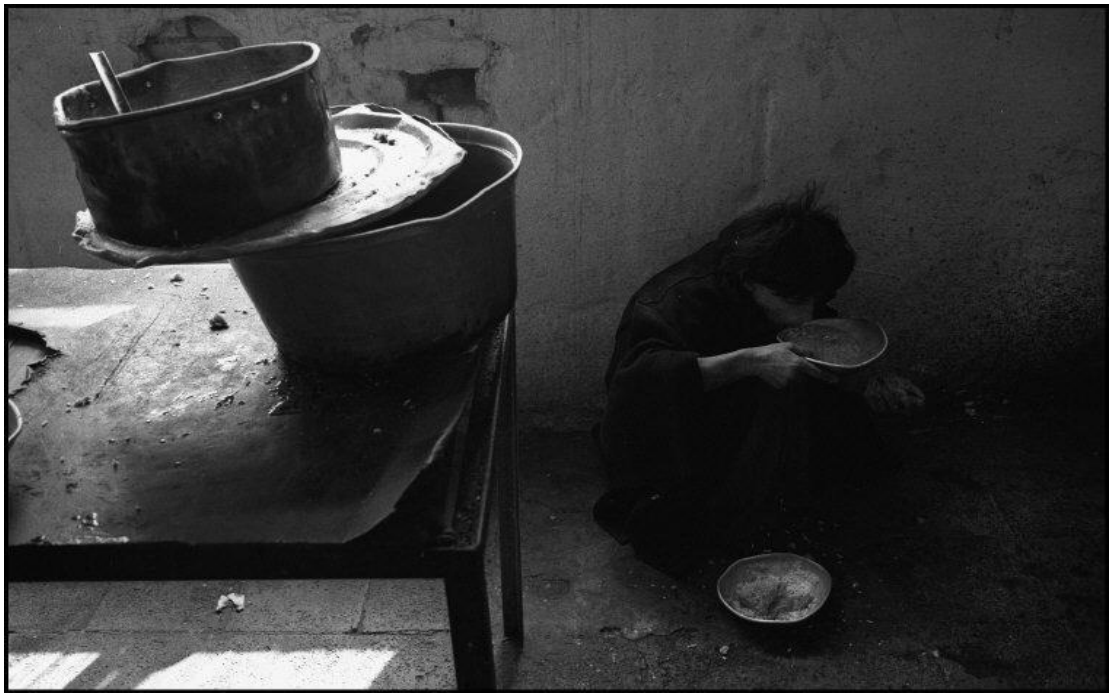

Figure 2. Elbasan Psychiatric Hospital in 1991 (Nikos Economopoulos\Magnum Photos, 1991b)

Figure 3. The Albanians (Ladefoged/VII, 1997)

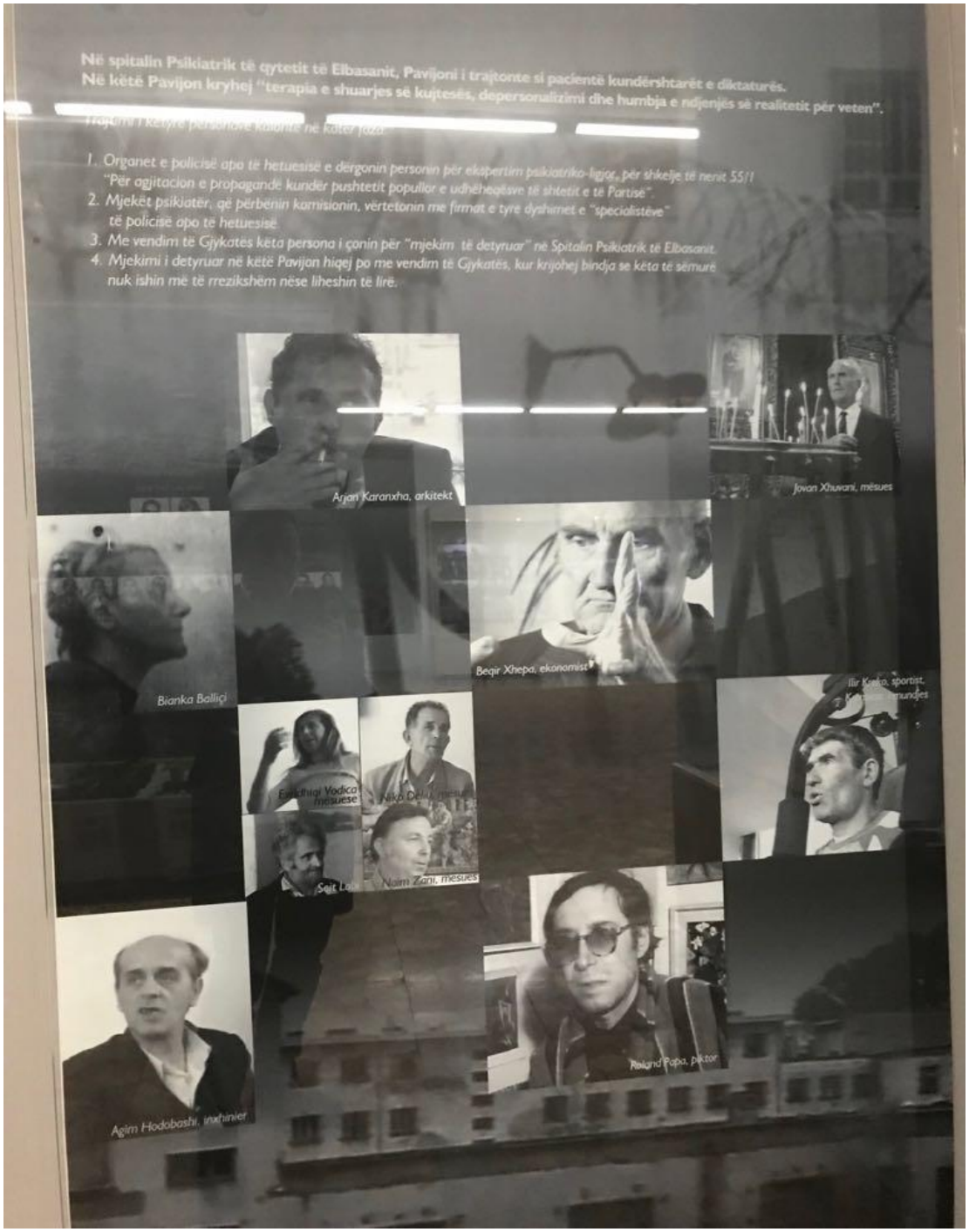

Figure 4. Political Victims of Communism Sent for Psychiatric Treatment at the Elbasan Psychiatric Hospital until 1991 (National Museum of Albania, 2017)

Figure 5. Elbasan Psychiatric Hospital, Albania 1991 (Nikos Economopoulos\Magnum Photos, 1991c)

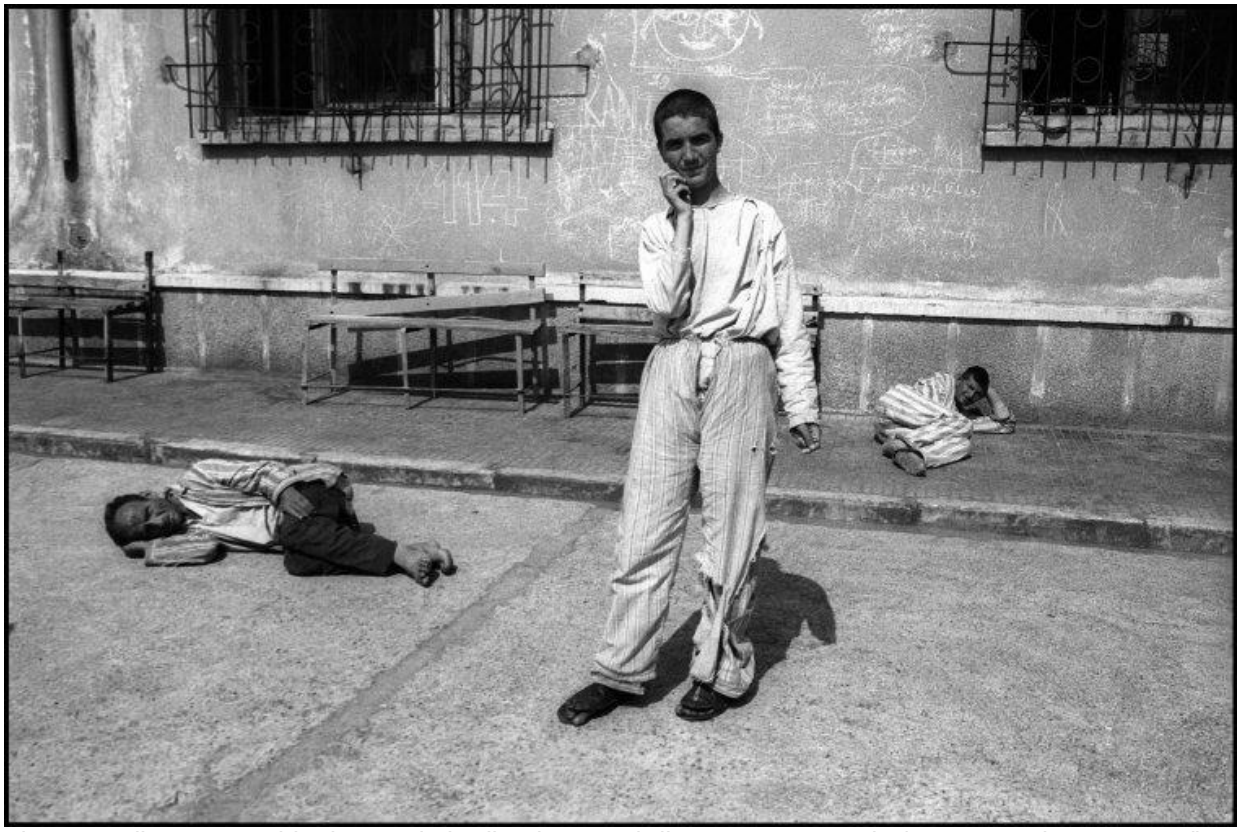

Figure 6. Elbasan Psychiatric Hospital, Albania 1991 (Nikos Economopoulos\Magnum Photos, 1991d)

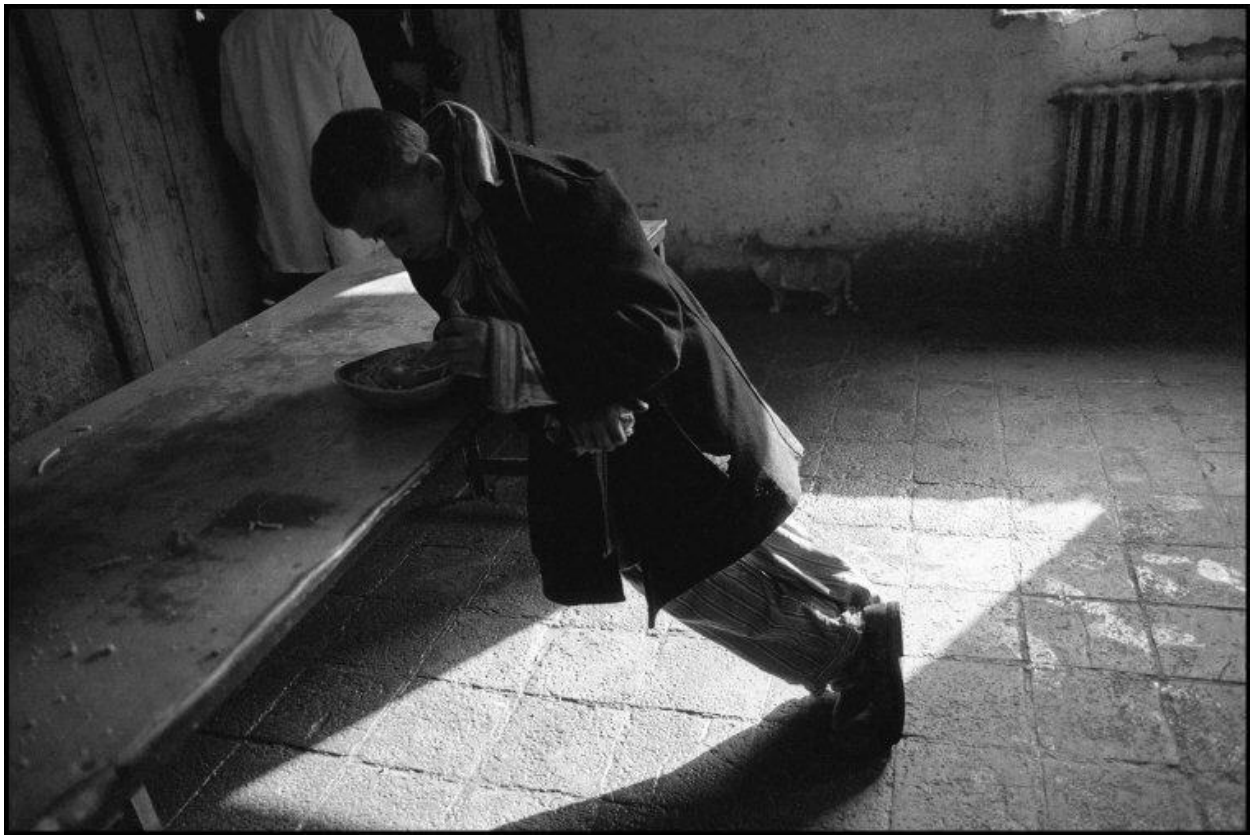

Figure 7. Elbasan Psychiatric Hospital, Albania 1991 (Nikos Economopoulos\Magnum Photos, 1991e)

Like other Eastern and Central European countries, Albania embraced the model of the 'Soviet Man'. Loss, grief and sadness did not belong in the newly constructed communist society and exhibiting such emotions was considered a deviation from generally recognized norms in the communist systems (Tomov et al., 2007; National Museum of Albania, 2017).

In general, the Albanian people lacked trust (Hutchins, 1996) in the mental health system, in particular, under the Communists. This was partly due to the consequences of encouraging individuals to spy on each other (National Museum of Albania, 2017); a lack of awareness and understanding of mental health issues; the societal and individual stigma attached to being mentally ill; and the lack of patient involvement in treatment choices given the health care system's top-down approach (WHO, 2011).

To conclude, not only was mental health in Albania outdated, poorly run and under-funded, it was also used by government to deliberately deny human rights.

1.2: COLLAPSE OF COMMUNISM IN ALBANIA: SOCIO-ECONOMIC CHANGES

The year 1991 marked the collapse of Communism, which was associated with public unrest aimed at denouncing the Hoxha regime. This is captured in Figure 8 below:

Figure 8. Collapse of "Hoxha" Monument Marking the Collapse of Communism in February 1991 (Muzeu i Memories, 2014a)

As the country moved towards a free-market democracy post 1990, its transition was both long and hard (Nuri and Tragakes, 2002). Even though Albania ranked in the upper middle income group based on the 2010 World Bank criteria, (WHO, 2011), Albania's real GDP per capita was estimated about $9,400 US in 2012, which placed it again amongst the poorest countries in the Balkans (WHO, 2014b). Further information pertaining to the collapse of Communism and its legacy on Albania can be found at the Muzeu i Memories website: http://muzeuimemories.info/en/.

Within the Albanian context, the quality of medical care at all levels of the health system continued to remain a significant problem during the post 1990 historic developments which included the fall of the Communist system and its state control, including economic scarcity which subsequently led to a free market system (World Bank, 2014).

Similar to the transition process which other former communist countries underwent, a market-oriented economic system was implemented and subsequently led to many socio-economic reforms (Nuri and Tragakes, 2002). These changes were associated with a sharp rise in unemployment (Nuri and Tragakes, 2002) and characterized by an intensive process of migration; it is estimated that 22-25% of Albanians have emigrated since the change of the political system in 1991 (Dyrmishi, 2010). The exodus of Albanians to neighboring countries, e.g., Italy, is captured in Figure 9 below:

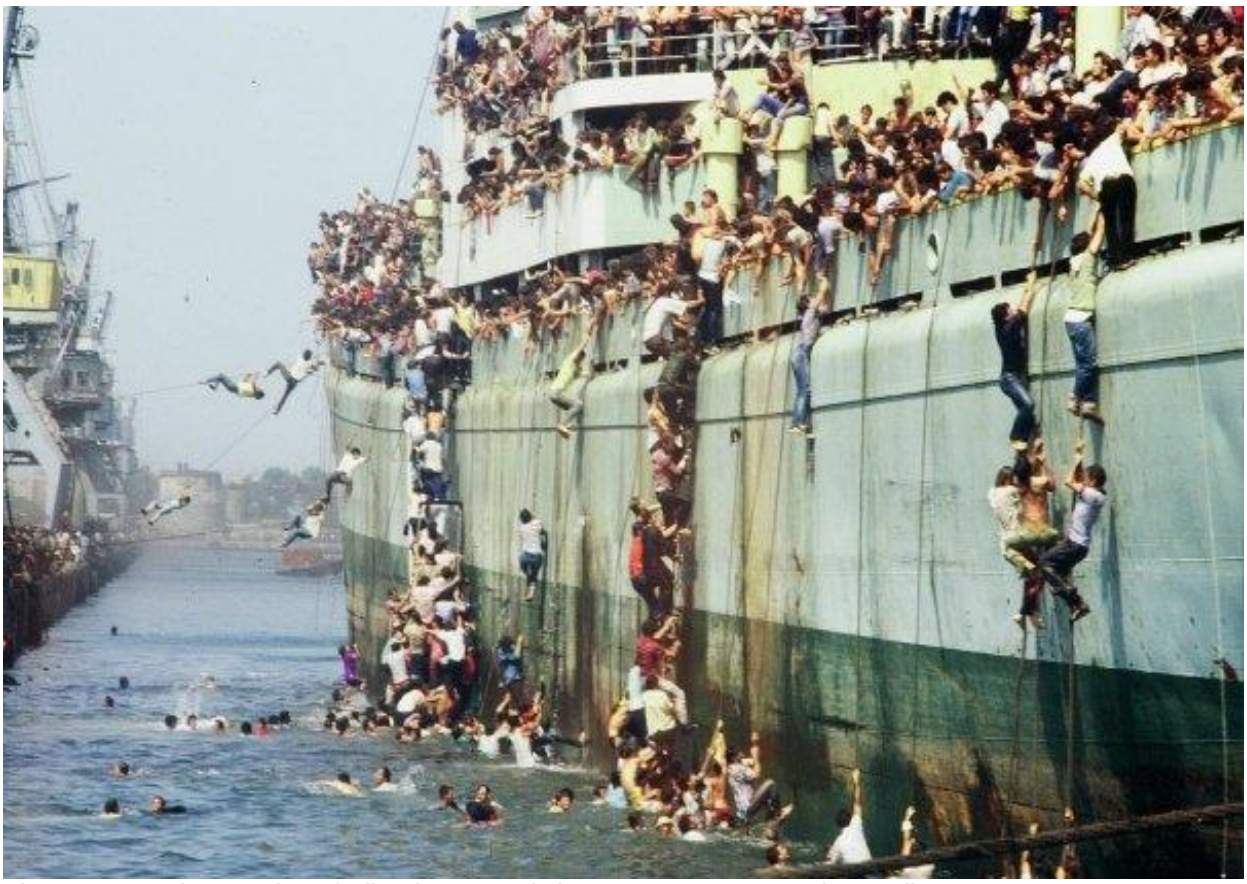

Figure 9. Massive Exodus of Albanians to Italy in 1991 Post Communism Collapse (Migrants at Sea, 2011)

Subsequent to these social and political changes post 1990s, there was an increase in mental and behavioural disorders, e.g., high suicide rate, domestic violence and crime (Demi and Voko, 2014).

1.3: MENTAL HEALTH SERVICE DEVELOPMENTS IN POST-COMMUNIST ALBANIA

The change in Albanian institutions led in 1995 to the initiation of the Health Care system reforms which became a major priority in the country (WHO, 2011). The Semashko model which existed during Communism left a legacy of poor quality care, which became apparent in the early 1990s and the Albanian government recognized the need to move towards the Bismarck model (Marku, 2010). Chancellor Otto von Bismarck, who the model is named after, invented the welfare state of Germany in the 19th century, which is a social insurance program financed jointly by employers and employees through payroll deduction (Wallace, 2013).

The Bismark model aimed to help prevent deterioration in health care as well as assist in the decentralization of primary care management to district public health directorates, followed by effective formulation and implementation of health policies and reforms (World Bank, 2014).

1.3.1: SUCCESSES AND CHALLENGES

The health care reform undertaken in early 2000 in Albania aimed at decentralizing the services as well as deinstitutionalizing the chronic mentally ill patients, both necessary because of the legacy of Albania's mental health system under Communism (Ministria e Shendetesise e Shqiperise, 2013; Demi and Voko, 2014). Even though the reform focused on shifting resources from hospital settings to community services, this shift was characterized by an inadequate infrastructure to support such changes (WHO, 2001b), as determined by cost-containment needs (Mueller, 2013). The reduction in the number of psychiatric beds per 100,000 population in Albania to 24, in comparison to Italy (8) and Greece (18), is an indication of low investment and absence of relevant infrastructure (WHO, 2011).

In addition, the opportunity for system innovation in mental health was met with staffing problems. Firstly, Albania has the lowest number of mental health professionals (psychiatrists, nurses, psychologists, etc.) per 100,000 inhabitants compared to other European countries and its neighbouring countries of Italy, Greece, Macedonia and Slovenia (WHO, 2008a; Como, 2015). As of 2010, only 4.1% of government health care expenditures were intended for mental health services, with 60% being directed to the community-based services, although Vlora and Elbasan Psychiatric hospitals remain the largest mental health settings in Albania (Demi and Voko, 2014). Despite changes to the system, financial constraints existed regarding the creation and staffing of community-based mental health services across the country (Ministria e Shendetesise e Shqiperise, 2013). Secondly, there was staff resistance (Demi and Voko, 2014), as it was in an Eastern Bloc country where prejudice and stigma, including self-stigma (Tomov et al., 2007), were predominant and necessitated a culture change (Menzies, 1992). The collective culture which sees the family as the primary source of support for its members with mental disorders remained prevalent (Lamcja, 2016).

To further advance and consolidate changes to the mental health system, Albania undertook a number of legislative and normative developments such as: the introduction of Albania's first Mental Health Act in 1996. This Act emphasised the role that the state should play in protecting mental health in Albania, in conjunction with associations and humanitarian organizations, including patient groups and their relatives. In addition, it highlighted the importance of implementing preventive mental health policies that aim at protecting mental health through the provision of health care and suitable social environments for mentally ill patients (The People's Assembly, 1996).

This Act unfortunately was mostly inapplicable as there were no supporting sub legal acts and regulatory documents approved to facilitate its implementation (Demi and Voko, 2014). Consequently, it was renewed in 2012 to promote the protection of the rights of persons with mental disorders compliant with international human rights conventions which led to the deinstitutionalization of mental patients by downsizing the number of beds in psychiatric inpatient services (Ministria e Shendetesise e Shqiperise, 2013). It also attempts to build on and support the care standardization process and its quality assurance mechanisms, i.e., outlining the legal and professional procedures and standards related to seclusion, including the decentralization of mental health services, by developing community-based mental health services (Demi and Voko, 2014).

Despite positive developments in the mental health care system, including the creation of community mental health centres (CMHC) that followed a top-down model, the result was poor client outcomes and client disempowerment (Mueller, 2014). The provision of supported homes, as well as two day centres within 'Sadik Dinci' psychiatric hospital in Elbasan did not respond to overall population needs with respect to volume and capacity leading to service access issues (Demi and Voko, 2014). Psychiatric hospitals in Vlora and Elbasan continued to be the largest mental health settings; their poor conditions were attributed to a range of factors, e.g., political corruption. This is captured in Figure 10 below:

Figure 10. Abuse with Hospital Funds in 2014 Leading to Inhumane Living Conditions at the "Ali Mihali" Vlora Psychiatric Hospital (Skuqi, 2014)

Despite indications that violence has been noted in mental health services in Albania (Muca, 2012), no study has been conducted to assess the full extent to which service user human rights are protected in the psychiatric units in the country following ratification of the CRPD on the part of Albania in 2013. The developments within the Mental Health field, are closely interconnected with improvements which occurred within the overall health care field, as the health care system underwent a series of changes. These changes are addressed in the next subsection.

1.4: HEALTH CARE SERVICE DEVELOPMENTS IN POST-COMMUNIST ALBANIA

Of particular importance has been the role that a few key stakeholders have played in supporting Albania's health system improvements, e.g., the World Bank (WB), WHO and others (World Bank, 2014). Despite this international aid, there have been few successes and challenges have continued to occur.

1.4.1: SUCCESSES AND CHALLENGES

On the one hand, progress was noted following the launch of the Health System Strategy 2007-2013 which led to improvements regarding the patient referral system. Other positive developments included the following: introduction of official fees, calculation of service costs, digitalization and 'informatization' of the health care system and improvement of the Health Institute functionality where private providers approved by the Ministry of Health are reimbursed by the Health Institute (Vian, 2011).

On the other hand, the quality of medical care in Albania has remained a major issue at all levels of the health system (Vian et al., 2006; World Bank, 2014) with a direct impact on Albania's health outcomes which have lagged behind those of other countries in the South East European Region even though they have compared favorably with those of lower middle-income countries outside Europe and Central Asia region (World Bank, 2014). A number of factors have impacted the quality of health care in Albania.

Firstly, the total health care expenditure in Albania is 5.9% of its GDP versus 8.5% - 9% in EU countries (OECD, 2017). Albania also continues to have the lowest per capita government expenditures in health ($142 US) in comparison to neighbouring countries such as: Bosnia ($340 US); Slovenia ($1490 US); and Italy ($2031 US) (Como, 2015). Such funding constraints are attributed to Albania's high public debt which exceeded 60% of GDP, e.g., in 2012 and 2013 leading to access service problems for disadvantaged groups. Health care expenditure is comparable with the former Eastern Bloc countries, yet, it involves a high share of private outlays and out-of-pocket expenditures (Bredenkamp et al., 2011). A large number of these are unofficial payments (Vian et al., 2006), as these informal payments have flourished in a few transitional countries (Chawla et al.,1998; Balabanova and McKee, 2002). For

example a survey carried out in Elbasan found that the public pays to secure access to quality of care (Lika, 2013).

Secondly, Albania is found to present with 4 types of corruption in the health financing system as follows:

- Informal payments (bribes to the medical health personnel stated as a condition of accessing quality care, and/or gift offering on the part of the public to the personnel as an expression of affinity and/or gratitude) (Vian, 2011);

- Hospital corruption (problems with procurement of tenders, including the case of the pharmaceutical contracts, abuse of medical hospital funds and supplies; bribing of politicians to get medication added to the essential list of medication) (Swedish International Development Corporation Agency [SIDA], 2008);

- Health insurance fraud (visits which never occurred; fraud in the pharmaceutical industry, etc.) (Forzley, 2007);

- Conflict of interest (physicians referring patients to private clinics which they have connections with; pharmacies purchasing medication which the hospitals did not offer and were not expected to offer, etc) (Vian, 2011).

Consumer input has indicated that almost all public health employees expect informal payments, independent of the consumers' health insurance status in exchange for easily accessing quality health services and bypassing excessive bureaucracy of the referral system (United States Agency for International Development [USAID], 2013). Their low salaries/low compensation issues are a significant contributing factor (Vian, 2011). The second factor impacting this phenomenon is the socio-cultural dimension of the Albanian culture of 'bakshish' (tip) behavior whereby consumers informally pay service providers (Marku, 2010). Thirdly, attempts to transform the system have encountered varying levels of difficulty including service provider change resistance (Vian, 2011; Demi and Voko, 2014). Fourthly, a few system inefficiencies have been noted due to the lack of performance standards which determine hospital budgets based on the number of beds (Marku, 2010). Last, the lack of universal health coverage due to unaffordability through the Albanian government health care schemes has presented with barriers to quality care on the part of marginalized population (Tomini et al., 2013; 2015).

Addressing quality of care challenges in general health care have led to efforts on the part of the Albanian government aimed at increasing health care sector accountability, civic engagement and reduction of informal payments (USAID, 2013). In particular, anti-corruption and quality of care improvement initiatives have been launched. These government initiatives are also driven by Albania's strong political and social will to join the European Union (EU) and embarking on opening EU accession negotiations (Kryeministria, 2014; EU, 2018).

1.5: ALBANIA'S POST 1990s SOCIETAL TRANSFORMATIONS: HUMAN RIGHTS

During Communism, a lot of people confessed to crimes they never committed, were declared mentally ill (National Museum of Albania, 2017) and/or chose to be considered mentally ill to escape ongoing torture, even though it was claimed torturing did not exist once captured (Muzeu i Memories, 2014). In an attempt to depart from its dark past, since 1991, Albania has aimed to establish a multi-party democracy as well as attempting to rapidly re-integrate into the international and European communities (World Bank, 2014). Once Albania had become a Parliamentary Republic, it developed acts which sanctioned human rights formally and legally. In this way, basic human rights and freedoms received attention and were considered the cornerstones of the judicial system (Kuvendi Populllor, 2003).

Albania became a member of the United Nations Human Rights Council in 2014 (Ministry of Foreign Affairs of Albania, 2015), highlighting Albania's formal commitment to the promotion and protection of Human Rights. Furthermore, it endorsed its ratification of a few international conventions, including the UN CRPD in 2013 (UN, 2016) on the basis of which relevant Albanian Acts, pertaining also to the protection of the rights of persons with disabilities, have been built. However, the Albanian culture continued to remain clan-based (Doll, 2003), collectivist and patriarchal (Kaser, 2000; Sawicka, 2013) and guided by canonistic laws (Bardhoshi, 2012).

The government also created, for the first time, the role of People's Advocate (Ombudsman) and Commissioner for Protection from Discrimination (UN, 2014) as well as capitalizing on its pursuit of equality of opportunity, and shifting from a focus on greater wealth to a focus on enhanced well-being (World Bank, 2014). The Ministry of Health of Albania developed Patient Rights which were reflected in the Patient Bill of Rights (Ministria e Shendetesise e Shqiperise, 2009); the Health Care Act (Ministria e Shendetesise se Shqiperise, 2013) and the Civil Code of Albania (The People's Assembly, 1991)**.**

The fall of Communism in Albania has generated economic growth and an improvement of human rights such as: democratic elections and freedom of speech (World Bank, 2014). The extent to which such improvements have been translated into an improvement of human rights for people with mental disorders in psychiatric units remains unknown. This question will be investigated via this study.

SECTION 2: SUMMARY

This chapter has presented a synopsis of factors and historic developments which impacted the quality of care and human rights of people with mental disorders in Albania during the Communist regime. It has shed light onto the outdated, poorly run and under-funded mental health services in Albania and the politicized role that mental health had during the Communist regime. In addition, this chapter has considered the legacy of the Communist regime and the changes which occurred to the health care system as well as the mental health services in Albania post 1991. It addressed positive developments in the health care services, including legislative developments in the Human Rights area. A range of challenges still prevalent in the health care system were highlighted, for example, corruption and poor quality of care in the health care.

It was noted that the fall of Communism in Albania has generated economic growth, an improvement of human rights and ratification of the UN CRPD, yet, the extent to which such improvements have been translated into an improvement of human rights for people with mental disorders in psychiatric units remains unknown. This necessitated the need for a study into human rights in psychiatric hospitals in Albania.

The next chapter focuses on the launch of the UN CRPD, and the development of the WHO QualityRights Toolkit as a response to evaluating the protection and promotion of human rights for people with mental disorders.

CHAPTER III: HUMAN RIGHTS AND MENTAL HEALTH AND THEIR INTERSECTIONS GLOBALLY

SECTION 1: WHO QUALITYRIGHTS TOOLKIT AND AN OVERVIEW OF HUMAN RIGHTS IN HEALTH CARE

This section provides an overview of the global prevalence of human rights violations amongst people with disabilities, the launch of the UN CRPD and subsequent to the latter, the WHO QualityRights Toolkit as an instrument which aims to assess the protection of the human rights of services users with mental disabilities (WHO, 2012b). In addition, this section provides a summary of varying human rights as embedded in international acts and relevant conventions, including raising questions about the assumptions behind the WHO Toolkit, particularly in light of its applicability within the Albanian context.

1.1: BACKGROUND

Mental disorders represent one of the biggest public health concerns globally. Estimates indicate that the global burden of mental illness accounts for 32.4% of years lived with disability (YLDs) and 13% of disability-adjusted life-years (DALYs). Consequently, mental illness is placed a distant first regarding YLDs, and level with cardiovascular and circulatory diseases regarding DALYs (Vigo, Thornicroft and Atun, 2016). Across the world, people with mental and psychosocial disabilities often face human rights violations, stigma and marginalization (Corrigan and Watson, 2002; Drew et al., 2011). In 2006, the UN CRPD established patient human rights standards as outlined in the WHO QualityRights Framework (WHO, 2012b). The launch of the WHO QualityRights Toolkit, in 2012, is of a particular importance as it delineates standards that every health care facility must respect, protect and fulfil in order to ensure optimal protection of patient human rights (See Appendix IV) (WHO, 2012b).This important development was in response to the long standing global neglect and violation of patient human rights in countries, including Central and Eastern Europe (Parker, 2007), which had become a prioritized area for action (Drew et al., 2011).

Comprehensive and integrated care that respects human rights is seen as a factor which leads to better health outcomes, improved functioning and recovery, reduced disability, and overall improved development outcomes for individuals, families and communities (Fletcher, 1992; WHO, 2000; Ozdemir et al., 2006; Funk et al., 2010; Drew et al., 2011*).* In addition it is seen as a factor which supports enhancement of system accountability (Valimaki, et al., 2009).

1.2: UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES AND QUALITYRIGHTS TOOLKIT THEMES

Unlike any other approach, the UN CRPD (See Appendix III) adopted in 2006, consolidates rights stated in other prior treaties and forms the basis for human rights standards that each service providing facility must respect, protect and fulfil (WHO, 2012b). The CRPD sees disability as a form of oppression. The world is seen as constructed by people with capabilities, for people with capabilities, hence, impacting the functioning of people with impairments (Finkelstein, 1988; Carter et al., 2017). Subsequently, one of the priority areas for action in the Comprehensive Mental Health Action Plan 2013-2020, adopted in May 2013 by the 194 member states of the WHO, has been the promotion of quality and respect for human rights (Saxena et al., 2013). The WHO QualityRights Toolkit, based on the CRPD, encapsulated these rights into standards in order to ensure optimal protection of patient human rights (WHO, 2012b) considering the global prevalence of human rights violations, and the stigma and marginalization of people with mental and psychosocial disabilities (Drew et al., 2011). Violations often occur (Kleinman, 2009) behind “closed or open doors” and go unreported and consequently unprevented (Hathway, 2002; Murdie, 2009), including in signatory states.

The WHO QualityRights Toolkit has been utilized in Afghanistan (Parwiz, 2015), Egypt (Fawzy, 2015), Somalia (Currie, 2012), Greece (Nomidou, 2012), Spain (Moreno, 2010), and Tunisia (Rekhis, 2015). The results of these studies have shown violations of service user human rights across all human rights categories of the Toolkit. For example, poor state of living environments were reported from studies in: Afghanistan (Parwiz, 2015), Egypt (Fawzy, 2015), Somalia (Currie, 2012), Greece (Nomidou, 2012), and Tunisia (Rekhis, 2015). Findings also showed that most service users still lived in hospitals rather than in the community, which is consistent with historical data that segregation of people with mental disorders and other disabilities in large social care and/or psychiatric institutions has been occurring in most countries across the world (Wing and Brown, 1970; Desjarlais et al, 1995; Thornicroft and Tansella, 1999; 2004). Findings from this study will be compared and discussed against findings from other countries where the Toolkit has been utilized in Chapter VI.

The WHO QualityRights Toolkit was chosen for its comprehensiveness and applicability to the theme of assessing mental health patient’s human rights as well as its proven suitability of use in low income, middle income and high income countries (O’Hara, 2012). The Toolkit draws from the recovery approach (Funk, 2016), challenges the social model, as well as the medical model, and recognizes that the limitations created by a disability are not just a problem of the person but rather a problem of the barriers set by society (Funk, 2016). The approach puts the emphasis on the person’s lived experience, choices and self-management, informed by a constructivist epistemology (Slade, 2012).

The Toolkit's five domains which appear to integrate both civil and political/first generation rights as well as socio-economic/second generation rights are:

- The right to an adequate standard of living and social protection;
- The right to enjoyment of the highest attainable standard of physical and mental health;
- The right to exercise legal capacity, the right to personal freedom and the security of person;
- Freedom from torture, cruel inhumane or degrading treatment, or punishment and from exploitation, violence and abuse;
- The right to live independently and be included in the community.

The following assumptions appear to inform the WHO QualityRights Toolkit:

- Human rights are universal rather than culturally and historically specific;
- It includes both negative human rights, i.e., freedom 'from' oppression, coercion, imprisonment without trial, and others;
- It includes positive human rights, i.e., freedom 'to' have well-resourced and well-functioning services, optimum and high quality of care, and others.

Western Liberalism has influenced the development of human rights globally (Heard, 1997), and therefore underlies the QualityRights Toolkit. Also underlying the Toolkit is the assumption that human rights are universal and the Toolkit is influenced by the recovery approach (Funk, 2016). The focus of the recovery approach is, amongst others, the promotion of rights and choices for people with disabilities (Chamberlin, 1978; 1995; Davidson et al., 1999; Bassman, 2000).

An important question is whether these assumptions affect the applicability and usefulness of the Toolkit within the Albanian context. A review of what human rights are is first warranted.

1.3: OVERVIEW OF HUMAN RIGHTS

The concept of human rights has been shaped and re-shaped for over 2000 years (Roy and Annicchino, 2014), ranging from ancient law to modern eras with a range of social movements advocating for the rights of vulnerable groups. Human rights are seen as universal, indivisible, interdependent and inalienable (Heard, 1997; Wenar, 2005). The origins of human rights are reflected in various documents, including: the Magna Carta (1215), which is seen as the foundation of future Bills/Charters of Rights in various countries (Danziger and Gillingham, 2004); the UN Universal Declaration of Human Rights which promotes a series of civil, cultural, economic, political and social rights (UN, 1948). Human rights are perceived to have a complex internal structure and their assertions come at a high price (Wenar, 2005). They are sanctioned in national and international treaties due to being seen as fundamental rights which encapsulate rules and norms and regulate how human beings should interact in relation to each other, including the state, around the world (Heard, 1997; Cohen and Ezer, 2013). Human rights are seen to represent negative and positive moral guarantees whose principles also apply to patient care (Cohen and Ezer, 2013).

These rights are categorized as follows:

- Civil rights referring to the freedoms of speech, religion, assembly, association;

- Economic, cultural and social rights referring to the right to participate in culture and work, the right to an adequate standard of living, the right to education (Mensch, 2010).

1.3.1: CURRENT DEBATE OVER THE NATURE OF HUMAN RIGHTS AND THE RESPECTIVE DOMINATING THEORIES

Despite the capturing of such rights in different treaties, a contemporary yet historic debate over the nature and function of human rights still exists: are human rights universal or relative/locally constructed entities? Of particular importance are the two most predominating views which either promote claims (“freedom from” others’ interference, including state’s, e.g., freedom from oppression, torture, etc.) or liberties (capacity for freedom or “freedom to enjoyment” of) (Gregg, 2011; Boylan, 2014). These categories are otherwise known as first generation/civil and political rights and their negative guarantees regarding freedom from others’ interference (including the state’s interference) and second generation rights *(*social and cultural rights/second generation rights), which are considered locally constructed (Watchirs, 2005; Mensch, 2010), and their positive guarantees regarding the state’s obligation to provide services for its citizens.

The controversy pertains to claims regarding their universal legal endorsement due to:

a) the ongoing debate regarding what first and second generation rights constitute: rights or claims;

b) their universal or relatively/socially constructed nature (Mensch, 2010).

The two most explanatory theories regarding the functions of human rights in the legal field are: the 'Interest Theory' and the 'Will Theory' which promote claims (freedom from others' interference, including the state's) and liberties (capacity for freedom) respectively (Gregg, 2011; Boylan, 2014).

These two theories reflect the debate between two influential philosophies which inform welfare states: Welfarism (Bentham's) and Kantianism (Kant's) respectively (Sen, 1979). Bentham, an interest theorist and Kant, a will theorist, entered a debate over the nature of rights which stretched back to the Dark Ages. Bentham saw people as not born free but subject to their parents, families, and societies control (Epstein, 1998), differently from authors such as Locke, who referred to the negative rights largely and saw that people must possess rights to life and liberty by obeying God (Tuckness, 2016), or Burke who saw rights as emerging from ancient and traditional laws and liberties (Harris, 2012).

Only when taken together do these theories offer a complete conceptual picture of rights, whereby some rights are considered privileges and some rights are considered claims (Wenar, 2005; Gregg, 2011). Interest theorists see rights with a purpose to promote the well-being of the rightholder. Interest theory endorses a wide range of rights and claims that having rights can enhance quality of life. It does not explain the function of rights which are not designed to benefit the well-being of the right holder (Wenar, 2005). This happens due to its claim that the function of rights is to promote the interest of the right holder, rendering the theory incorrect for "rights" as they are commonly understood (Wenar, 2005).

The will theorists, or choice-based approach, recognize as potential right holders only those with capacities to exercise powers (Wenar, 2005). The Will Theory is largely critiqued as it renders certain categories of peoples as rights-absent, i.e., with respect to acknowledgement of rights only by persons competent enough to exercise these powers/liberties. For instance, disabled adults and children are excluded (Wenar, 2005).

Despite the explanatory functions of these two competing theories, they are critiqued for their "single-function" nature as theories of rights. They postulate that all rights have some single function, yet they differ as to what that function is. In addition, their explanations do not explain the wide range of human rights (Wenar, 2005; Donnelly, 2011).

The several function theory rises above claims that rights have single functions. The several functions theory attempts to resolve the tension that exists between two

single function theories. It claims that rights have all functions for the right holder (Wenar, 2005; Gregg, 2011).

1.3.2: THE HUMAN RIGHTS-BASED APPROACH AND THE UN CRPD

The UN sponsored a disability-based human rights convention (CRPD) in which disabilities of varying types both physical and mental are added to the existing group of basic rights based on the disability human rights paradigm. Marginalized people, including those with mental health problems are the individuals who would require protection (Stein, 2007).

The convention defines disability as the interaction between persons with impairments and attitudinal with environmental barriers that do not allow them to be seen as fully participatory and on an equal basis with the rest of the society (UN, 2007). It differs from the other main approaches which aim to define disability. First, the charity approach which sees persons with disabilities as victims of their circumstances requiring compassion care from due to their inability to self-sustain. Secondly, the medical approach whose focus is on curing people incapacitated due to their disability and inability to live independently (Oliver, 1996) and the position of power that medical personnel have in the relationship with people with disabilities. Thirdly, the social approach (Finkelstein, 1988) which views disability as the outcome of the erroneous way in which society is organized, e.g., presence of environmental barriers which should be eliminated for people with disabilities to participate fully in the society, with an emphasis on the state and society as duty bearers of such functions (Stein, 2007).

Differently from all these approaches, the Human Rights approach, views disability rights as invoking civil and political rights, along with economic, social and cultural rights, hence, it positions the disability framework as a strong platform for viewing human rights protections, e.g., the right to mental health and the right to health, as being equally indivisible (Stein, 2007; Gable and Gostin, 2009). It intersects with as well as it borrows from Nussbaum's capability approach (Stein, 2007) which values individuals dignity, autonomy and capability of living a meaningful life; therefore, offering a normative theory of human rights as well as pointing at increasing policy accountability on the part of governments (Stein, 2007). More specifically, the human rights in patient care approach highlights the active role that marginalized and vulnerable people can have in the formulation of health law and policy guidelines, coupled with training for health care providers as well as an active role in advocacy and litigation to address violations of their human rights (Cohen and Ezer, 2013).

Specifically, within the mental health context, the CRPD, refers to the legal duty of the state to ratify the convention and develop mechanisms that speak to the development of the legislation and policies whose focus is implementation of these rights and their monitoring (O'Flaherty, 2002; WHO, 2008a). With regard to mental health, as mental health is an inseparable aspect of health, the right to mental health is seen as inseparably related to other human rights, e.g., the right to health which contains both freedoms (freedom from torture; involuntary detention without due process and others) and entitlements (access to the highest available standard of mental health services) and is embedded in international human rights instruments

(Gable and Gostin, 2009). Despite the slow recognition of the right to mental health within the international human rights law, including the marginalization of mental health and intellectual disabilities within the disability rights movement. Establishing and upholding affirmative mental health rights can advance the dignity and welfare of persons with disabilities, and their ability to enjoy other human rights, as is the right to health (Gable and Gostin, 2009).

In summary, the WHO QualityRights Toolkit which appears to be influenced by the human rights-based theory, embodies the view that all rights are of a universal nature and their overall functions are to promote both freedom from abuse and neglect, as well as freedom to access services in the mental health settings.

1.4: OVERVIEW OF HUMAN RIGHTS IN HEALTH CARE

Human rights, in the context of patient care, are closely intertwined with quality of care (Drew et al., 2011; Cohen and Ezer, 2013). They surround the patient-provider relationship; they provide for standards in the provision of care which concerns health providers and the society at large, as well as an examination of systemic factors and the state's role and responsibility in the provision of health care (Cohen and Ezer, 2013).

It is clear that some progress has been made in the area of human rights protection for people with mental disabilities. However, no single country has achieved an outstanding state of development and compliance with legislation and policy, which includes advocacy pursuit, as well as the relevant protection and implementation mechanisms and standards of care that will support and promote the human rights of people with mental disorders (Drew and Funk, 2016). Furthermore, implementation of patient rights is found to be highly variable across facilities and nations due to political, socioeconomic and cultural variability.

One of the factors pointed at is the prevalence of neo-liberalism and its influences on the patient rights' approach. Despite criticism of neo-liberalism, it is considered by many to have had a profound impact on the culture of health care delivery as a whole and on the recovery movement in the mental health field as well (Adeponle, Whitley and Kirmayer, 2012). Consumer choice, a key feature of the patient rights' approach which is influenced by neo-liberalism, is promoted due to the importance of patient satisfaction with quality of care and the choice of facility they receive care from, among other choices that they can pursue (Hekkert et al., 2009; Tambuyzer et al., 2011). However, a question arising is the extent to which vulnerable and/or impaired people fully pursue choices available in an ever expanding market which does not address their complex needs (Cohen and Ezer, 2013). The capabilities human rights-based approach which the CRPD is based on, in contrast to other perspectives, e.g., patient rights', addresses human rights and associated complexities. Complications arise due to the dual role that the state is known to play. While it creates a premise for respecting patient's autonomy, it is also faced with the obligation to beneficence (referring to involuntary psychiatric treatment of suicidal and/or homicidal patients who can harm others or be harmed by their own actions due

to impaired mental capacity) (Robertson and Walter, 2008). Yet, the grounds for involuntary admissions remain variable across countries (Cullen-Drill and Schilling, 2008; Cairns et al., 2010).

The next section visits key developments in the mental health field internationally and their impact on mental health.

SECTION 2: TACKLING MENTAL HEALTH

This section aims to provide an overview of changes in the mental health field at a global level, and the much warranted changes which the field is still experiencing. Key models of policy implementation are referenced as they directly intersect with global changes within the mental health field and human rights protection.

2.1: TACKLING MENTAL HEALTH: MENTAL HEALTH POLICY IMPLEMENTATION GAPS

The most significant development regarding promotion of human rights of people with mental disorders has been the deinstitutionalisation process of the psychiatric health care system from asylum-management-based to community-based systems. This change has happened in response to advocacy work for freedom from inhumane treatment, equality and a right to an independent life which began in the 1970s in a few Western countries, e.g., Italy and the UK, spearheaded by international movements, e.g., the Human Rights Movement and the Disability Rights Movement (Stein, 2007; Adeponle, Whitley and Kirmayer, 2012). It has been a key mental health policy implementation item across the Western countries (WHO, 2008a). The deinstitutionalization process was influenced by a number of factors; humanism: the promotion of quality and respect for human rights as well as the drive to reduce costs (Wagner et al., 1996; Dietrich et al., 2004).

One of the main critiques of the deinstitutionalization process in Western countries was the fact that it was not preceded by a robust community infrastructure to help deinstitutionalized patients transition and settle well in the community (Monahan et al., 2003; Gable and Meier, 2013). Issues identified as contributing to poor health outcomes for clients after deinstitutionalisation were, for example, the inequalities in mental health care (Knapp et al., 2007; Wise and Sainsbury, 2007) and the presence of a significant amount of lasting stigma and discrimination towards people with mental disorders (Drew et al., 2011) from staff (Corrigan et al., 2003; Kleinman, 2009; Thornicroft et al., 2009) with an impact on quality of care and patient quality of life (WHO, 2008b).

A key mental health policy implementation gap refers to the significant ‘treatment gap’ between the need for mental health services and receipt of them (Kohn et al., 2003; WHO, 2012a). This treatment gap is particularly noticeable in low-income and lower middle-income countries (WHO, 2004b; 2013) due to the limited funding which mental health care receives which often is less than 2% of total health expenditure versus 5% total health expenditure in high-income countries (WHO, 2013; Knapp and McDaid, 2007). Funding limitations are evidenced to have direct implications for quality of care, service development and equity (WHO, 2008b).

In conclusion, despite the increased attention that mental health has received across a few countries over the past few years, there are still a number of mental health policy implementation gaps with a direct impact on quality of care and subsequently, on the human rights of people with mental disorders.

SECTION 3: KEY MODELS OF POLICY IMPLEMENTATION

All existing policy implementation models have relative utility (Matland, 1995). Bennett and Howlett (1992) state that policy change refers to development of new polices or small changes to existing policies, and it is closely interconnected with policy implementation (Fullan, 2007); the latter often determines the outcome of a launched policy (Pressman and Wildavsky, 1984). While Albania has launched health care reforms and subsequently policy developments post 1991, as earlier indicated in this thesis, implementation of these policies has not resulted in marked positive changes in the health care. Successful implementation does not always follow policy changes; it depends on a number of variables (Fullan, 2007). These factors are discussed in Chapters: II, III and VI.

One key policy change model which is worth referring to in the context of Albania's developments is: the path dependency model (Wilsford, 1995; Pierson 2000) which speaks to the concept of difficulty in achieving policy change due to key stakeholder unwillingness to change (Greener 2002) as addressed in chapters II,III and VI.

There are a few models of policy implementation; the following are presented for their high applicability to health care as they apply to the Albanian health care context:

3.1: THE TOP-DOWN MODEL

This model is characterized by centrally located authoritative decisions by key stakeholders who expect desired outcomes (Van Meter and Van Horn, 1975; Mazmanian and Sabatier, 1983). It capitalizes on the funder/government rationally planning and establishing goals and overseeing their implementation in a hierarchical way which may not be understood by those whose job it is to follow the new policy; because they do not understand, they may be less supportive of the change (Matland, 1995; de Leon and de Leon, 2001).

3.2: THE BOTTOM-UP MODEL

Unlike the other model, the bottom-up model capitalizes on the role played by the service delivery stakeholders in policy implementation; it aims to tap into their agency for change based on the rationale that they are key policy implementation actors (Berman, 1995). The bottom-up model challenges the top-down approach for its disconnect from the service recipients and service deliverers (de Leon and de Leon, 2001).

3.3: THE COMBINED APPROACH

The combined approach has often been preferred in policy implementation in order to build on the strengths of both the top-down and bottom-up approach (Matland 1995; Sabatier and Jenkins-Smith, 1999). Use of each approach in a combined way is seen as dependent on the level of political conflict regarding the policy focus, whereby a high conflict context is associated with the top-down approach, and a low conflict context is seen in the case of bottom-up approaches (Suggett, 2011). Relevant recommendations on how these policy implementation models can be built on within mental health services in Albania will be made in Chapter VI.

SECTION 4: SUMMARY

This chapter presented a synopsis of a broad array of developments in the mental health field globally, most importantly the CRPD in 2006 (UN, 2014; 2016) and subsequently, the launch of the WHO QualityRights Toolkit as an instrument which aims to assess the protection of the human rights of services users with mental disabilities (WHO, 2012b). Key theories of human rights and their inherent tensions, were addressed.

Global gaps in key mental health policy implementations, particularly with regard to the challenges that the deinstitutionalization process of chronic service users with mental disorders has faced, received attention, followed by key models of policy implementation. To conclude, regardless of the increase of the attention that mental health has received internationally over the past few years, quality of care gaps and human rights concerns in mental health service continue to exist across countries including signatory states of the CRPD.

The next chapter focuses on the study methodology and research methods used to collect study data.

CHAPTER IV: METHODOLOGY AND PROCEDURES

This chapter provides a detailed overview of the methodology, design and procedures chosen in conducting this study. It refers to the conceptual framework informing this study as well as paving the way for justifying the use of and critiquing the WHO QualityRights Toolkit. It also makes reference to study limitations.

SECTION 1: THE RESEARCH PARADIGM AND PROCESS

1.1: STUDY AIM, OBJECTIVES AND RESEARCH QUESTIONS

Albania was chosen as the study setting because it presents a fascinating case study given the impact of its long standing communist past on human rights, particularly in the mental health field.

The Aims of the Study are:

- To explore the protection of human rights among patients attending the Psychiatric Inpatient Units at the 'Ali Mihali' Vlora Psychiatric Hospital and at the 'Sadik Dinci' Elbasan Psychiatric Hospital, in Albania, using the standards of the WHO QualityRights Toolkit;
- To provide a critique of the WHO QualityRights Toolkit within the Albanian context.

The Objectives of the Study are:

1. To explore service users', family members' and staff awareness regarding service user human rights;
2. To explore how staff awareness of service user human rights impacts staff practice;
3. To use mixed-methods to explore the extent to which service user human rights at the Psychiatric Inpatient Units are protected and promoted;
4. To provide a critical analysis of the QualityRights Toolkit and determine its validity within the Albanian context, including differences in application between psychiatric and comparison surgery units, if any;
5. To disseminate study findings amongst key Albanian stakeholders, e.g., hospital stakeholders, service users, family members.

The Research Questions are:

- Do the Albanian Psychiatric Inpatient Units at the 'Ali Mihali' Vlora Psychiatric Hospital and the 'Sadik Dinci' Elbasan Psychiatric Hospital meet Human Rights standards?

- To what extent does the WHO QualityRights Toolkit accurately measure human rights protection within the Albanian perspective?

The Research Secondary Questions are:

1. Are negative rights met in the Psychiatric Inpatient study settings?
2. To what extent can positive rights, within the mental health context, be met in a developing country such as Albania?
3. How does poor quality of care become a human rights issue in the Psychiatric Inpatient Units?
4. Are there any differences in human rights protection between the Psychiatric Inpatient services and the Surgery units? If so, what factors/themes may speak to any reported differences?

To strive to answer the research questions raised, this study adopts a mixed-method methodology which aims to compare WHO QualityRights Toolkit findings collected at the Psychiatric Inpatient Units at the two largest Albanian psychiatric hospitals in Elbasan city and Vlora city against Toolkit findings from the Surgery Inpatient Units at the respective General Hospitals in Elbasan city and Vlora city. The rationale for data comparison is to explore any differences that exist between quality of care and promotion of patient human rights in mental health settings versus general health settings, as suggested in the WHO QualityRights Toolkit methodology (WHO, 2012b).

1.2: SELECTION OF RESEARCH PARADIGM AND METHODOLOGY

Methodological diversity presents with advantages compared with the limitations of using a single paradigm (Hoshmand, 1989). This study draws from both the constructivist paradigm and the critical realism paradigm. The constructivist paradigm promotes a hermeneutical-dialectical research methodology consisting of qualitative data and naturalistic inquiry (Guba and Lincoln, 1994). On the other hand, critical realism (Bhaskar, 1975), similar to constructivist realism, claims that social order exists independently of social scientific inquiry, even though such order is evident only through human transactions (Bhaskar, 1975).

The constructivist paradigm is largely influenced by Berger and Luckmann's (1966) social construction of reality view and Lincoln and Guba's naturalistic inquiry (Lincoln and Guba, 1985). Of particular importance is the claim it makes regarding the development of human subjective meanings through experiences and interactions situated within specific social and historical context, highlighting the social aspect of constructivism (Newman, 2000; Schwandt, 2000). The constructivist view of human behaviour draws from postmodern perspectives for which the absolute truth does not

exist and the linguistic paradigm in social sciences appreciates how language creates realities (Elder-Vass, 2012). In the context of the mental health profession, 'mental illness' and 'diagnoses' are arbitrary social constructs (Walker, 2006). These terms are often associated with a lot of stigma and are found to directly impact client/patient recovery (Henderson, Evans-Lacko and Thornicroft, 2013). However, the constructivist viewpoint alone does not suffice to address human rights concerns in mental health and society at large.

Unlike social constructionism, critical realism and critical realists, such as Bhaskar (1975), Archer (1995), and their followers, focused on the nature of causation, agency, structure, and relations as well as ontology (Gorski, 2013). They claim that reality and its causal factors have tangible consequences for human beings, despite the fact that many social categories could be socially yet differently constructed, which may lead to varying quality of outcomes (Gorski, 2008).

Both paradigms appear to inform the WHO QualityRights Methodology which this study is based on. On the other hand, the QualityRights Toolkit informed by CRPD's framework, adopts a capability human rights-based approach which sees human rights protections, e.g., the right to mental health and the right to health, as being indivisible. This is because disability rights invoke both positive and negative rights (Stein, 2007; Gable and Gostin, 2009). Consequently, this study uses an evaluative mixed-methods triangulation study design with an in-between method of triangulation (Creswell, 1994; 2014): qualitative semi-structured one-on-one interviewing, qualitative observations and reviews of records and policies/guidelines, to investigate patient human rights at the two Psychiatric Inpatient Units.

This is a qualitative dominant mixed research study, wherein priority is given to the qualitative aspect of data (Johnson et al., 2007). The sequencing of methods chosen (Creswell, 1994; 2014) determines which type of data is collected first. In this study design, the qualitative data collection and analysis occurred first followed by the complementary quantitative stage so that the qualitative findings could aid the interpretation of the quantitative part. This is known as the QUAL → Quan type, (Morse, 1991) which allows for a better and deeper understanding of studied phenomena (Fielding and Fielding, 1986; Denzin and Lincoln, 2000) given that neither method in isolation would effectively address the nature of the research problem (Ivankova, Creswell and Stick, 2006).

Qualitative research has been found better suited for dealing with a specific issue given the amount of detailed data which it collects (Bryman, 2012). Quantification of qualitative data is done in an effort to maximize the limited generalizability of the phenomena described, within its given context (Silverman, 1985), focusing on reflecting the participants' own ways of comprehending their social world (Bryman, 2012). This in itself creates a fertile terrain for further work to occur with larger sample sizes.

The main rationale for using this design was to obtain complementary data on the same topic (Morse, 1991) given triangulation's nature as an epistemological claim (Bryman, 2012), and to minimize any bias that may be inherent from different data sources, for instance, investigator's bias (Jick, 1979). This study included investigator

triangulation (Webb et al., 1966) as well, given that the assessment committee, with diverse representation, collected different data, e.g., observational data, on the same topic. The observational methods when studying health and health services help circumvent the biases inherent in the accounts individuals provide regarding their actions which are often influenced by factors such as: wishing to present themselves in a good light and recall differences; observational methods also help to uncover themes which participants may not be aware of (Mays and Pope, 1995). The visiting/assessment committee strove to write memos in an unobtrusive way (Armstrong, 1993; Maykut and Morehouse, 1994) on the QualityRights Toolkit Observation Sheets (WHO, 2012b).

As the mixed-methods model allows for quantification of the qualitative findings (Tashakkori and Teddlie, 1998), the data can then be compared via the use of cross-case comparative analysis (Miles and Huberman, 1994) whose main function is to identify social patterns, any influencing factors and to understand the specificities of local contexts (Rouse, 2008). Comparison groups were recruited from the Surgery Inpatient Units at the respective General Hospitals in Elbasan city and Vlora city. The rationale for data comparison is to explore whether there are any differences in the quality of care and protection of human rights, e.g., freedom from torture and inhumane treatment, in psychiatric settings versus Surgery Inpatient Units.

The underlying assumption based on the WHO QualityRights Toolkit methodology is that there might be different factors which impact the quality of care in psychiatric and other health units (WHO, 2012b), on the basis of the perceived differences in protection of rights and quality of care provided across the world to people with mental illnesses versus people with other physical health needs (Funk et al., 2010). For example, 'Cinderella services' is a term referring to low priority services, such as the mental health services, in the UK (Orr, 2013).

A limitation from the methodological standpoint is that senior management of the psychiatric hospitals did not approve of photo taking of study participants nor audio recording of interviews. None of the study participants agreed to have the interviews audio taped, either, due to fear of reprisal, which largely resembles the common mistrust during the Hoxha system (Hutchins, 1996). This potential for reprisal had implications regarding data collection in that decisions on what to collect were impacted by concern for study participants and the possible outcomes such as participant reprisal.

1.3: PHILOSOPHICAL POSITIONING

The constructivist paradigm has a relativist epistemology (Walker, 2006) that takes into consideration the expectations, values, backgrounds and roles of the health care settings and patients (Alderson, 1998). Given Berger and Luckmann's (1966) challenge to the notions of objectivity, reality and truth, social constructionism as an approach focuses on meaning and power where meaning is considered a by-product of the prevailing cultural framework of any social and symbolic practices and discourses (Young and Colin, 2004). Specifically, social constructionist theories consider how health personnel and patients construct/reconstruct their interacting

realities (Alderson, 1998) which are shaped by cultural and historical forces (Goffman, 1963), as is the case of human rights (Gregg, 2011) and mental illness (Walker, 2006). Subsequently, cultures create unique beliefs regarding what constitutes health, including poor mental health/craziness (Helman, 2000), or anxiety (Alderson, 1998).

This phenomenon has led to the stigmatization of people with mental illnesses, particularly those who have been institutionalized. Worldwide, mentally ill people are often constructed as dangerous and a threat to social order, a construction which has informed the policies of institutionalization that many countries have pursued (Funk et al., 2010). These socially constructed notions of mentally ill patients have adversely shaped the quality of care for such people (Monahan et al., 2005; Funk et al., 2010) and raised concerns about human rights which the UN CRPD attempts to address (UN, 2007).

On the other hand, there is unique value in considering the critical realism views of Bhaskar (1975), that although problems are socially constructed, there are still causal links that lead to different outcomes, e.g., different cultures value human rights differently, particularly in light of the notion that there tends to be a lack of human rights in non-Western political and cultural tradition (Donnelly, 1982). Human rights are perceived to be a byproduct of individualism, liberal democracy, and political and social liberties (Huntington, 1996). These differing views reflect the tension between constructivist and universalist accounts of mental illness (Markowitz, 2004a) and human rights (Gregg, 2011), which relates to the conflict between relativism and realism (Hammersley and Atkinson, 2007).

In order to address such tensions, this study adopts a mixed-method research study design to assess the human rights of people with mental illnesses in Albania's psychiatric hospitals. The predominating philosophy behind mixed-method research study designs is pragmatism, and this appears to intersect with the constructivist standpoint that has both a pragmatic and relativistic nature (Creswell, 2014) and claims that there is no single valid and ideal methodology (Johnson et al., 2007), subsequently, triangulation is recommended. Similarly, the philosophy of critical realism is compatible with methodological triangulation purposes (Risjord et al., 2001) and it helps establish validity and reliability of qualitative studies within the realism paradigm (Healy and Perry, 2000). Therefore, the mixed-methods study design appears to satisfy both paradigm views: constructivism and critical realism. As earlier referred to, the WHO QualityRights Toolkit capitalizes on both investigator triangulation (data collection) and data triangulation (data analysis) which enhances study validity and objectivity (Denzin and Lincoln, 2000). Consequently, the QualityRights Toolkit is positioned to address the research questions this study raises.

1.4: VISITING/ASSESSMENT COMMITTEE

A multi-disciplinary assessment committee of experts with expertise and/or interest in protecting and promoting the human rights of people with mental illnesses or disability was formed. The committee members were as follows:

- Gjergj Sinani, Professor of Philosophy, Faculty of Sociology and Philosophy, University of Tirana, author on human rights protection and nominee for the Ombudsman's office in 2014;

- Mrs. Eva Filaj, Clinical Psychologist, with extended expertise in auditing of human rights protection in Albanian correctional services;

- Mrs. Zhaneta Kala, Social Worker;

- Mr. Elidon Janina, community member and advocate for people with mental illnesses and disability rights;

- Ms. Laura Loli-Dano, Candidate, Doctorate in Health, with experience in provision of and/or management of mental health services as well as promotion of human rights.

1.4.1: TRAINING OF THE ASSESSMENT OF THE ASSESSMENT COMMITTEE

All members of the assessment committee were independent of any target facilities, and/or government sections responsible for overseeing hospitals in Albania. They all signed a non-disclosure agreement to conduct the assessment voluntarily and declared no conflict of interest. All Toolkit domains were assessed by applying a project management framework carried out by the visiting/assessment committee (WHO, 2012b). While the study is based on use of the WHO QualityRights Toolkit and I received coaching by WHO, in 2015, on use of this Toolkit, I designed the study, organized the assessment committee and trained its members for 5 days in summer 2016 on the use of the WHO QualityRights Toolkit. Following the training, the committee members decided upon the roles and responsibilities of each committee member, including the scoring mechanisms, weight of various sub-themes and consensus reaching mechanisms. The committee agreed that the fieldwork should be coordinated by the doctoral student. I also wrote the first draft of the assessment report based on the findings and finalized it as per the recommendations of all members of the committee. All assessment committee members determined ratings of standards/sub-standards based on joint consensus of average data individually collected. Phenomena which were observed by one/few committee members only, e.g., violation of involuntary admissions policies, determined the final ratings agreed by all committee members.

The assessment committee members met with hospital staff and management teams (all sites), service users and family members, on site, at the facility during the pre-assessment visit to explain the purpose of the assessment as well as the steps involved and establish a sense of partnership amongst all study groups.

1.5: DATA GATHERING

Data gathering was based on the assessment of human rights and quality of care at the Psychiatric Inpatient Units at the “Ali Mihali” Vlora Psychiatric Hospital and the “Sadik Dinci” Elbasan Psychiatric Hospital, and from the Surgery Inpatient Units at the respective General Hospitals in Vlora city and Elbasan city, in Albania.

Specifically, three types of data were collected:

1) Qualitative semi-structured one-on-one interviews were conducted with service users, family members and staff given the advantages that this method offers, e.g., depth and clarity of information gathered (Maykut and Morehouse, 1994; Patton, 2002);

2) Consistent with the qualitative observation and naturalistic research principles, the researcher/visiting/assessment committee collected additional data as a complete observer via direct observation of conditions in Inpatient Units; and

3) A review of relevant documentation (for instance, policies, service user files) was conducted which provided for a comprehensive description (Geertz, 1973) of the human rights situation.

I, the primary researcher, an Albanian Canadian female, was a doctoral candidate, a Certified Canadian Counsellor and a Registered Social Worker in Ontario, Canada, at the time of the interviews. I had also worked as a professional translator for social services and government agencies in Canada. I translated the QualityRights Toolkit into Albanian, as well as translating the interviews into English. The translations were then given to the other two interviewers, who both spoke English, to review for accuracy and translate the toolkit back into English.

Data gathering occurred between December 2016 and January 2017. Interviews and a review of service user files and all relevant documents, e.g., administrative records: number and categories of staff, age and gender of service users, etc., were conducted by the doctoral student and two other committee members. Site observations were conducted by all committee members. The committee decided to conduct two unannounced and one announced visit at each study hospital. The unannounced visits allowed for observation of the conditions which service users experienced at different times of the day and week in order to collect data on existing realities within such hospitals.

A central component of the data gathering process was a focus on the QualityRights Toolkit's (WHO, 2012b) five human rights themes (See Appendix IV). A review of documentation was another important part of the assessment. The WHO QualityRights Documentation and Observation tool was used as a guide to the visiting/assessment committee members on the types of documentation to be reviewed in the assessment. During the pre-visit, a list of the requested documentation was shared with authorities of each hospital in advance in order to allow sufficient time to provide such information. The management teams did not reveal the number of service users under voluntary or involuntary status. No data on complaints against staff were released either. The files of service users who were selected for interview, were examined in depth to ascertain whether they were up to date, when medication was last reviewed, if informed consent for treatment was being obtained, if treatment plans and advance directives were being developed in collaboration with service users and if service users themselves could add information to their files, as per WHO's suggested methodology (WHO, 2012b).

Staff and family members inquired whether interviews were either part of government initiatives or media ('Fiksi Fare') initiatives to tackle corruption and poor quality of care in the Health Care sector in Albania. Such initiatives have led to loss of staff's workplace position, staff imprisonment and other professional practice consequences, e.g., the former executive director of 'Sadik Dinci' Psychiatric Hospital in Vlora was fired and legally prosecuted for corruption in 2013 (Skuqi, 2014). Family members also expressed fear of reprisal on the part of staff onto service users, given the latter party's vulnerability within such institutions.

Interviews were held in a private room, were conversational in nature and lasted an average of 1 hour, except for breaks taken during interviews. All interview results were captured on the WHO QualityRights Toolkit Interview sheets. According to the studentship agreement, the University of Bath owns all data I create, yet, I can retain the copyright on publication based on the data which I have collected as per various stakeholders' requirements (See Table 1).

Interviewees received an explanation on voluntary participation and the right to withdraw from the study at any time and all signed the consent forms prior to interviews being conducted (Ryen, 2004). Some service users, who were visited by family members at the interview time, asked to have their family members present during the interview process and this was accommodated. Digital photographs of physical settings only from all study sites were taken.

1.6: ETHICAL CONSIDERATION

The Visiting Committee and I strove to ensure the dignity, rights, safety and wellbeing of all participants in the research, including avoiding unreasonable risk or harm to them all as well as to the environment where the study took place. Ethical approval was obtained from the Management Teams of each hospital/unit in Vlora city and Elbasan city as well as the Research Ethics Approval Committee for Health, at the University of Bath before embarking on the data collection process. This study was based on guidelines and principles which are captured in Table 1 below:

Table 1: University of Bath Data Retention and Management Relevant Policies/Guidelines

No.	Policy/Guideline
1	The Albanian Personal Data Protection Act (2008) (country context based)
2	Research Ethics and Integrity Guidelines
3	Research Ethics and Governance Guidelines
4	Ethical Implications for Research Requirement
5	Code of Good Practice in Research Integrity
6	University Ethics Policy
7	Research Ethics Approval Committee for Health (REACH)
8	Intellectual Property Policy
9	The IT Security Policy
10	Data Protection Policy
11	Information Classification Framework (ICF)
12	Principles of Research Assessment and Management
13	University Handbook for Research Students
14	Faculty of Humanities and Social Sciences Graduate School Postgraduate Research Handbook 2015/16
15	Concordat to Support Research Integrity
16	The Data Protection Act 1998
17	The Freedom of Information Act 2000
18	The Department of Health Research Governance Framework for Health and Social Care 2005
19	The Mental Capacity Act 2005
20	The Safeguarding Vulnerable Groups Act 2006
21	The Human Rights Act 1998

Signed consent forms were kept securely and could only be accessed by the committee members to protect participant confidentiality and anonymity. Confidentiality, the obligation to protect the participants' identity and their context (Ryen, 2004) is related to the concept of non-maleficence. Warren and Karner (2005) have suggested that human subjects can be protected from the possibility of having their identity revealed. This pertains to both anonymity by removing participants' names as well as data confidentiality and ways of securing it, e.g., data encryption.

While each participant's anonymity is protected, we were concerned that we could take action in the event of serious abuses of patient rights, e.g., patients who are physically abused as disclosed by either staff or patients. Therefore, the following steps were agreed by the assessment committee:

1) From the very beginning of the study staff were informed that serious abuse of service user human rights cases would be reported to the management team of the hospital even though no obligatory 'duty to report' policy exists in either hospital;

2) Service users were assured of the protection of their anonymity as indicated in the Study Consent Form and Patient Information Sheet (See Appendix I).

In addition to all participants' written consent to partake in the interview being mandatory, patients were also asked to consent to have their medical chart reviewed. The proposed study was considered to be research with minimal risk. However, there was potential for the 'Hawthorne effect' to take place. The Hawthorne effect refers to the change of behaviour on the part of the study subjects due to their awareness of being observed (Roethlisberger and Dickson, 1939). Announcing the time of the visits may have created premises for staff to influence service users' responses in preparation for 'the visit'. For example, during the unannounced visits, the interviewers observed instances where staff's tone in speaking with service users shifted from harsh to soft tone of voice once their interactions were witnessed by the interviewers.

Participants were fully informed of potential risks and benefits. Necessary protective factors were in place should patients have experienced any distress prior, during and/or after the interview process:

1) Service user's affect was monitored just prior and during the interview;
2) Service users were free to discontinue the interview;
3) Service users could access treatment immediately if his/her condition deteriorated during the interview process. However, no such incidents happened during the course of data collection. Staff expressed their willingness to assist in any way warranted.

Even though there were no immediate direct personal benefits for the interviewees, this study provided them with the opportunity to voice their opinion on their experiences and will hopefully raise awareness of how service user human rights should be promoted and protected in mental health facilities. Neither the doctoral student nor any other members of the visiting/assessment committee engaged in any

clinical activities in the course of conducting the interviews because this fell outside the scope of the interviewer role.

Special attention was paid to service users with additional disabilities, e.g., poorly sighted, deaf or blind. The patient information form and flyer was available in large print and audio tape for poorly sighted/blind clients; a sign language interpreter (provided by an Albanian NGO) was available to assist deaf clients to communicate with the visiting/assessment committee.

Lastly, the assessment committee ensured that study participants were informed of the next study steps and dissemination of data.

SECTION 2: THE RESEARCH DESIGN

2.1: EVALUATIVE MIXED-METHODS TRIANGULATION STUDY DESIGN

We have seen above that the research questions informed an evaluative mixed-methods triangulation (data transformation model) study design with an in-between method of triangulation (Creswell, 1994; 2014). This, in turn, informed data collection via semi-structured interviews based on the QualityRights Interview Questionnaire. The QualityRights Toolkit, covering five human rights themes and the respective standards, (WHO, 2012b) was used to collect data from all three study participant groups. The Toolkit also contains questions associated with each criterion to assist the interviewees. An abbreviated version of the Toolkit Themes and Standards is found in Appendix IV. As stated earlier, all Toolkit domains were assessed by applying a project management framework carried out by the visiting/assessment committee (WHO, 2012b).

2.2: ELIGIBILITY CRITERIA

Qualitative approach principles largely informed this study. The inclusion criteria was largely founded on the researcher's tentative assumptions (Patton, 1990; Sprenkle and Moon, 1996), e.g., presence of human rights violations at the Psychiatric Inpatient Units post ratification of the CRPD on the part of Albania in 2013 (UN, 2016).

The criteria used to determine eligibility for the three groups were as follows:

Service users who were older than 18 years of age and able to consent to treatment, including involuntary admitted service users, receiving care at the Psychiatric Inpatient Units at both 'Ali Mihali' Vlora Psychiatric Hospital and 'Sadik Dinci' Elbasan Psychiatric Hospital. Service users who suffered from an organic brain disease who did not have decision making capacity, were excluded from this study. These service users could be a focus of another study.

Family members/friends who had a loved one receiving care at one of the Psychiatric Inpatient Units or Surgery Inpatient Units and those who visited service users admitted during the course of the study period.

Members of staff, including interdisciplinary clinicians, e.g., licensed physician, psychiatrist, social worker, psychologist, nurse as well as auxiliary members of staff, e.g., administrative support staff and personal support workers.

2.3: SAMPLING/SAMPLE SIZE

The goal was to engage a maximum variation purposive sample, which is a non-probability and selective sample that allows for group heterogeneity and capturing data variability (Creswell, 2014) in order to increase the robustness of the qualitative findings. This allowed for the purposive identification and selection of maximum variation information-rich cases, e.g., selection of participants with varying range of experiences of the studied matter, service users with varying length of stays in hospitals as well as from different inpatient units: acute and chronic units; as well as members of staff representing various disciplines (Creswell, 2014).

The purpose of the purposive sampling is not generalization of findings to the whole population, given sampling limitations, but to highlight common parallels between the setting observed and others like it (Mays and Pope, 1995). For instance, this enabled a comparison of the data collected between the two psychiatric hospitals in Vlora and Elbasan. Purposive sampling was not used to select family members because of the low number of family members visiting service users. For this group, opportunity sampling (Henry, 1990) was used. This method was also used if participants who were approached first declined to participate in the study.

All three groups of participants: service users, family members and staff, were chosen based on the presumption that their accumulated data would help explore the area of interest in-depth. The numbers of interviewees needed to achieve this was not possible to predict in advance (Maykut and Morehouse, 1994). However, based on WHO QualityRights Methodology, which this study draws from, a minimum of 12 service users out of the overall number of service users could be interviewed, should the hospital occupancy be 40 service users or higher (WHO, 2012b). The number of interviews with family members could be arrived at by halving the number of interviews conducted with service users, i.e., a minimum of 6 family members (WHO, 2012b). Similarly, the number of members of staff was selected on the basis of the same proportions used for service users, i.e., a minimum of 6 members of staff (WHO, 2012b).

Table 2 captures the number of interviewees as follows:

Table 2: Number of Interviews Held per Category of Study Participants

Hospital Study Sites	**Service Users interviewed out of total number of service users**	**Members of Staff interviewed out of total number of staff**	**Family Members Interviewed**
"Ali Mihali" Vlora Psychiatric Hospital	13 out of 147	6 out of 144	6
"Sadik Dinci" Elbasan Psychiatric Hospital	12 out of 325	7 out of 193	6
Surgery Inpatient Unit Vlora Regional Hospital	10 out of 32	6 out of 20	6
Surgery Inpatient Unit Elbasan General Hospital	10 out of 34	7 out of 21	6
Totals:	**45**	**26**	**24**

In the psychiatric hospitals, the sample of service users included adult males and females with different diagnoses, ages and lengths of stay from all inpatient units within the hospital: acute and chronic units. The sample of members of staff included males and females from all inpatient units within the hospital: acute and chronic units. If any of the selected interviewees refused the interview, the team continued to approach other prospective participants. One family member only refused to participate in the interview at the "Sadik Dinci" Psychiatric Hospital in Elbasan city, out of fear of reprisal against his hospitalized family member. One member of staff declined to part take in the study out of fear of losing their job in the same hospital.

Sample selection was similarly conducted at the Surgery Inpatient Units. No service user interviewees and family members refused to be interviewed at either unit. One member of staff declined to part take in the study at the Vlora Regional Hospital Surgery Inpatient Unit.

2.4: METHODOLOGICAL RIGOUR

Trustworthiness and authenticity are considered to be important in qualitative and mixed method research, as attributes for establishing methodological rigour (Lincoln and Guba, 1985; Denzin and Lincoln, 2000). Whilst trustworthiness considers the quality of the research product and examines issues related to credibility and dependability, authenticity looks at the quality in the inquiry process. To enhance the credibility, the following aspects were built into the research design: ongoing researcher's reflexivity (May and Pope, 1995) and engagement and assessment team debriefing and note keeping (Lincoln and Guba, 1985). This was conducted in light of collecting sensitive data in the context of Albania with its long standing history of human rights violations.

My extensive experience with the subject matter as a researcher and practitioner enhanced the credibility of the study as well as enabling the conversation to flow more naturally. Processing of the results involved the engagement of an academic supervisor and a practice-based supervisor with extensive experience in providing advice and facilitating the development of the research process. The assessment team debriefed after each visit at each study site (3 visits per study site x 4 study sites = 12 times). I, the doctoral student, and Gjergj Sinani, Professor of Philosophy, the practice-based supervisor, facilitated the debriefing meetings. Debriefing meetings also led to discovering the socially constructed themes resulting from the interviews, e.g., mentally ill people do not have many rights.

SECTION 3: DATA MANAGEMENT

3.1: DATA RETENTION

Research data was processed with the utmost rigour and integrity while protecting respondents' anonymity as outlined in the research ethics (REACH Form) application and the data management plan. Study participants were identified by coded identification numbers only. The materials are fully anonymized in the thesis and/or any future publications. Interview sheets collected during the interviews are stored in a locked filing cabinet within my office. My translated interviews are stored on my office computer, which is protected by a password. All data is encrypted and access to data is limited to visiting study team members only.

All electronic data related to this study will be protected in accordance with the regulations of the relevant stakeholders. According to the Albanian Personal Data Protection Act (The Assembly, 2008) and the UK Data Protection Act (UK Parliament, 1998), the electronic research data collected should be retained for a period of at least ten (10) years, after which it can be destroyed.

All interview hard copies in Albanian will be destroyed upon completion of the study. No secondary data analysis is presently planned for the data. However, it is possible that the data may be re-analyzed in light of future research interests and projects. This information was provided in the Patient Information Sheet/Consent Form (See Appendix I). No ethical issues in how the findings will or could be used in the future are identified and/or expected to arise.

Participants' written consent was obtained in the event that data is published. No other restrictions would impact the publication of study data. I will archive the data supporting my findings upon degree completion as per University of Bath Research Data Retention and Management Policy (University of Bath, 2014).

3.2: THEORETICAL CODING AND DATA ANALYSIS

Data collected via the semi-structured interviews were analyzed using thematic analysis, a most common data analysis method, to identify, analyze and report themes in data (Bryman and Burgess, 1994) via use of NVivo 11 (QSR International, 2011).

Detailed information about data coding outcomes/themes is found in Chapter V. All the written interviews with study participants were uploaded to the software. Use of NVivo helped with the construction and reconstruction of codes into categories during the coding and analysis process (Patton, 1990). Thematic inductive analysis was the main method used to explore themes identified under each category/standard/theme of the QualityRights Toolkit, given its rapid nature for analyzing large amounts of information (Trochim and Donnelly, 2007).

In carrying out the analysis, firstly, I read the completed WHO QualityRights Toolkit sheets several times and recorded preliminary notes. From these notes, I identified qualitative sub-themes within each “Standard/Theme” category of the QualityRights Toolkit and gave each one a code. Producing initial codes and numbering them (Bryman and Burgess, 1994) was based on identifying relevant data, e.g., instances of abuse of service users; instances of involuntary admissions. Secondly, the use of the axial coding hierarchical method led to grouping codes into a group of their own under each human rights standard/theme, e.g., physical building conditions (run down washrooms; crowded rooms, etc.) which referred, for example, to the extent the ‘Right to an adequate standard of living’ was met. This was consistent with Miles and Huberman’s (1994) recommended analysis when the unit of analysis is a case, which is any bounded unit, e.g., group, as are the 5 themes/standards of the QualityRights Toolkit. I also included examples of specific cases and participant quotations (May and Pope, 1995). I generated the final report by selecting examples of themes and relating findings to the literature (Bryman and Burgess, 1994).

In addition, I was mindful of data saturation; this is the point in the process of data collection when collecting more data will not reveal any new information related to the research questions (Holton, 2010), and when no further coding becomes feasible (Guest, Arwen and Johnson, 2006) as a result of data triangulation (Denzin and Lincoln, 2000). Data saturation occurred between 8-9 interviews in each study setting, following the review of all relevant documents, even though themes could emerge as early as after 6 interviews (Glasser, 2007).

A review of all relevant documents, as earlier stated, and the Observation Tool, which was utilized by the visiting/assessment committee during announced and unannounced visits, were used to assess each QualityRights Toolkit Human Right Theme (WHO, 2012b).

Overall, the QualityRights Toolkit is comprised of 5 Human Right Themes, which refer to a series of 25 'standards' which are further broken down into a series of 111 'criteria' in the WHO Toolkit (See Appendix IV). The scoring of each of the criteria under the particular standards was collectively and subjectively weighted and averaged, enabling the visiting/assessment committee to determine whether or not a particular standard had been met. Specifically, they were classified in terms of four levels of achievement as follows: A(achieved)/F(failed), A(achieved)/P(partially), A(achieved)/I(initiated) and N(not)/I(initiated), This was consistent with WHO recommended methodology (WHO, 2012b). An important methodological issue was the weight different aspects of the assessment had on the overall assessment results.

An example of WHO QualityRights Toolkit Theme/Standard rating formulation/assessment (excerpt taken from the “Sadik Dinci” Elbasan Psychiatric Hospital is provided as follows:

Criteria	**Interviews**	**Documentation Review**	**Observation**	**Result**
Criterion 1.1.1	A/I	N/I	A/I	A/I

Descriptive statistics regarding patient demographic data, e.g., age, gender; length of hospitalization were also collected; the latter was critiqued in light of best evidence practices occurring in other countries.

Before the study findings were formalized and disseminated to interviewee groups, the results of each theme were discussed by all visiting/assessment committee members and agreed upon to determine if the facility meets any human right standards.

3.3: DATA DISSEMINATION

A Facility-Based Assessment Report was produced; its findings were shared with various stakeholders, e.g., hospital management teams, staff, service users, to enable study sites to address the areas of concern regarding human rights, as well as build on areas of strengths already identified in this study. In addition, reporting back the study results is tied in with the notion of credibility (Lincoln and Guba, 1985). Establishing credibility refers to both following rigorous research procedures as well as submitting the findings to the people studied for their confirmation of the findings as consistent with their world view, otherwise known as respondent validation (Bryman, 2012).

To conclude, the collaborative approach of the study with the hospitals' leadership teams helped minimize the risk of potential resistance by staff and management to the assessment of services.

SECTION 4: SUMMARY

This chapter presented the research methodology, detailing the use of an evaluative mixed-methods triangulation study design with an in-between method of triangulation. This study is informed by the social constructionist and critical realism perspectives. The qualitative semi-structured one-on-one interviewing, qualitative observations, records and review of policies/guidelines sought to address the research objectives and questions that were identified in Chapter II. A total of 97 respondents were interviewed to explore patient human rights at the Psychiatric Inpatient Units at the "Ali Mihali" Vlora Psychiatric Hospital and "Sadik Dinci" Elbasan Psychiatric Hospital in Albania.

I have striven to adhere to ideas and processes that were consistent with the triangulation methods, namely, inductive thematic analysis and analysis of descriptive statistics during the data collection and analysis phases. I have also adhered to the methodological and ethical rigour of qualitative and mixed-method research methodology throughout the research process.

This study provides fertile grounds for future and in-depth research into the area of human rights for people with mental illnesses. The data analysis and key findings of this study are reflected in the next chapter.

CHAPTER V: FINDINGS

This chapter presents the data analysis and key findings from the data collection process of all 4 study hospitals. It presents a comparative summary of data collected at the “Ali Mihali” Vlora Psychiatric Hospital, against the data collected from the “Sadik Dinci” Elbasan Psychiatric Hospital. Similarly the data collected from the General Hospital of Vlora is compared against the data collected from the General Hospital in Elbasan for the purpose of highlighting any quality of care differences and subsequently any differences in protection of human rights between psychiatric and general hospital surgery units.

SECTION 1: HOSPITALS KEY DATA AND PARTICIPANTS DEMOGRAPHIC DATA

1.1: PSYCHIATRIC HOSPITALS KEY DATA

Table 3 shows that the “Sadik Dinci” Psychiatric Hospital has a considerably larger number of service users than the “Ali Mihali” Psychiatric Hospital despite transferring 22 beds to supported homes (Lamcja, 2016).

Service users with a length of stay over 10 years represented the largest number of service users at both psychiatric hospitals. The length of stay of service users in both hospital is shown in Table 3 below:

Table 3: Length of Stay of Service Users

	“Ali Mihali” Vlora Psychiatric Hospital Number of Service Users	**“Sadik Dinci” Elbasan Psychiatric Hospital Number of Service Users**
Less than 1 year	34	65
From 1-5 years	29	82
Over 5-10 years	17	54
Over 10+	67	124
Total Number of Service Users	**147**	**325**

Data relating to the two psychiatric hospitals is presented in Table 4. Bed capacity has decreased in years in both hospitals, yet, room occupancy remains over 12 service users per room in both hospitals. The number of multidisciplinary staff is higher at the “Sadik Dinci” Psychiatric Hospital than at the “Ali Mihali” Psychiatric Hospital. All psychiatric hospital data is presented in Table 4 below:

Table 4: Psychiatric Hospitals' Key Data

	"Ali Mihali" Vlora Psychiatric Hospital	**"Sadik Dinci" Elbasan Psychiatric Hospital**
Year of establishment	1921	1964
Bed Capacity (Past)	280	500
Bed Capacity (Present)	200	310
Bed Capacity (At time of study)	147	325
Emergency Room Bed Capacity	9	8
Sub-acute Unit Capacity	34	65
Population Covered Area	860,000 inhabitants	1,363,903 inhabitants
Room Capacity	12+ (chronic service users)	12+ (chronic service users)
Number of Community Based Units		
Number of Community Mental Health Centres	1 in Vlora	1 in Elbasan
Number of Supported Homes	3 in Vlora (34 service users accommodated)	2 in Elbasan 1 in Cerrik (22 service users accommodated)
Number of Staff by Profession:	144	193
Psychiatrist	5	6
Other Specialty Physician	2	2
Nurse	30	67
Psychologist	3	3 + 1 (in the outpatient centre)
Social Worker	2	2 + 1 (in the outpatient centre)
Occupational Therapist	3	4
Personal Support Worker	30	38
Auxiliary Staff	Unavailable data	Unavailable data

1.2: PSYCHIATRIC HOSPITALS STUDY PARTICIPANT DEMOGRAPHIC AND DIAGNOSTIC DATA

Table 5 shows that at the "Ali Mihali" Vlora Psychiatric Hospital, 9 service users were males and 4 were females and they were an average of 42.3 years old (range 21-50). At the "Sadik Dinci" Elbasan Psychiatric Hospital, 7 service users were males and 5 were females and they were an average of 44.5 years old (range 18-60).

The mean length of stay of the study service users was higher at the "Sadik Dinci" Psychiatric Hospital than the same variable of the respective study participants at the "Ali Mihali" Psychiatric Hospital. At the "Sadik Dinci" Psychiatric Hospital, the mean length of stay was 82.3 months (range 0.5 – 156); at the "Ali Mihali" Psychiatric Hospital, the mean length of stay was 52.7 months (range 0.25 – 240).

Service users with schizophrenia and schizoaffective disorder represented the largest cohort of service users who participated in this study in both hospitals. Service users' demographic, diagnostic and length of stay data are presented in Table 5 below:

Table 5: Service Users: Demographic and Diagnostic Data

	"Ali Mihali" Vlora Psychiatric Hospital	**"Sadik Dinci" Elbasan Psychiatric Hospital**
Gender:		
Men	9	7
Women	4	5
Age:		
Mean Age	42.3 years	44.5 years
Standard Error of the Mean ($SE_{\bar{x}}$)	2.6	3.4
Age standard deviation	9.4	11.9
Length of Stay:		
Mean length of stay for all service users	52.7 months	82.3 months
Standard Error of the Mean ($SE_{\bar{x}}$)	27.4	34.4
Length of stay standard deviation	98.9	119.3
Diagnosis:		
Schizophrenia	2	4
Schizoaffective disorder	5	3
Mental Health (schizophrenia and substance dependency)	1	0
Bipolar/Psychosis/Affective disorder	2	2

Psychotic disorder	2	0
Personality disorder with substance dependency	1	0
Concurrent disorders (mental health and developmental delays)	0	3

Table 6 below shows all study participants interviewed under the 'Family Member/Family Friend' category were family members rather than family friends at both psychiatric hospitals.

Table 6: Family Members/Friends: Demographic and Relationship with Service User Data

	"Ali Mihali" Vlora Psychiatric Hospital	**"Sadik Dinci" Elbasan Psychiatric Hospital**
Gender:		
Men	2	3
Women	4	3
Relationship Status with Service User:		
Family member	6	6
Family friend	0	0

Table 7 shows that the highest number of study participants under the category of 'Members of staff' were females at both psychiatric hospitals. At the "Ali Mihali" Vlora Psychiatric Hospital, members of staff were an average of 46.7 years old (range 21 - 52). At the "Sadik Dinci" Elbasan Psychiatric Hospital, were an average of 42.9 years old (range 26 – 57).

The mean length of experience of members of staff was similar at both psychiatric hospitals. At the "Ali Mihali" Psychiatric Hospital, the mean length of employment was 14 years (range 2 – 43); at the "Sadik Dinci" Psychiatric Hospital, the mean length of employment was 13.5 years (range 3 – 32).

Members of staff demographics, professional status, as well as length of experience is shown in Table 7 below:

Table 7: Members of Staff: Demographic and Diagnostic Data

	"Ali Mihali" Vlora Psychiatric Hospital	**"Sadik Dinci" Elbasan Psychiatric Hospital**
Gender:		
Men	1	2
Women	5	5
Age:		
Mean Age	46.7 years	42.9 years
Standard Error of the Mean ($SE_{\bar{x}}$)	6.3	5.02
Age Standard Deviation	15.6	13.3
Length of Professional Experience:		
Mean Length of Professional Experience of members of staff	14 years	13.5 years
Standard Error of the Mean ($SE_{\bar{x}}$)	6.3	4.6
Length of Professional Experience Standard Deviation	15.4	12.06

1.3: GENERAL HOSPITAL SURGERY UNITS KEY DATA AND STUDY PARTICIPANT DEMOGRAPHIC DATA

Table 8 shows that bed capacity in both surgery units in Vlora city and Elbasan city was similar, yet the number of members of staff is higher at the Surgery Inpatient Unit in Vlora than at the surgery inpatient unit in Elbasan.

Table 8: General Hospitals Surgery Inpatient Units' Key Data

	Vlora Regional Hospital Surgery Inpatient Unit	**Elbasan Regional Hospital Surgery Inpatient Unit**
Year of establishment	1916	1945
Bed Capacity (Present)	40	40
Bed Capacity (At time of study)	32	34
Population Covered **Area**	Over 400,000 inhabitants	Over 430,000 inhabitants
Room Capacity	1 – 4	1 – 4
Number of Members of Staff by Profession:		
Surgeons	6	6
Other Specialty Physician	2 Urologists 1 Plastic Surgeon 3 Orthopaedic Surgeons 5 Anaesthesiologists	1 Urologist 1 Plastic Surgeon 2 Orthopaedic Surgeons 4 Anaesthesiologists
Nurse	16	10
Occupational therapists	2 shared with the hospital	1 shared with the hospital
Social Worker Psychologist	0 1 shared with the hospital	0 1 shared with the hospital
Housekeeping Staff	Contracted out	Contracted out
Auxiliary Staff	Shared with the hospital	Shared with the hospital

Table 9 shows that at the Surgery Inpatient Unit in Vlora, 6 respondents were males and 4 respondents were females and they were an average of 55.4 years old (range 18 - 78). At the Surgery Inpatient Unit in Elbasan, 9 respondents were males and 1 respondent was female and they were an average of 41.85 years old (range 21 – 64).

The length of stay of service users was similar in both hospitals. At the Surgery Unit in Vlora, the mean length of stay was 2.7 days (range 2 – 4); at the Surgery Unit in Elbasan, the mean length of stay was 2.6 days (range 1 – 3). Service users' demographic and length of stay data are presented in Table 9 below:

Table 9: General Hospitals Surgery Inpatient Unit Demographic Data

	Vlora Regional Hospital Surgery Inpatient Unit	**Elbasan Regional Hospital Surgery Inpatient Unit**
Gender:		
Men	6	9
Women	4	1
Age:		
Mean Age	55.4 years	41.85 years
Standard Error of the Mean ($SE_{\bar{x}}$)	6.9	3.9
Age standard deviation	21.7	10.4
Length of Stay:		
Mean Length of stay for all service users	2.7 days	2.6 days
Standard Error of the Mean ($SE_{\bar{x}}$)	0.3	0.16
Length of stay standard deviation	0.8	0.52

Table 10 shows all study participants interviewed under the 'Family Member/Family Friend' category were family members rather than family friends at both Surgery Inpatient Units.

Table 10: General Hospitals Surgery Inpatient Units Family Member Demographic and Relationship with Service User Data

Family Member Demographic and Relationship with Service User Data	**Vlora Regional Hospital Surgery Inpatient Unit**	**Elbasan Regional Hospital Surgery Inpatient Unit**
Gender:		
Men	4	3
Women	2	3
Relationship Status with Service User:		
Family member	6	6
Family friend	0	0

Table 11 shows that the highest number of study participants under the category of “Staff’ were females at both Surgery Inpatient Units. At the Surgery Inpatient Unit in Vlora, members of staff were an average of 38.2 years old (range 21- 52) at the Surgery Inpatient Unit in Elbasan, members of staff were an average of 41.9 years old (range 26 – 57).

The mean length of experience of members of staff was higher at the Surgery Inpatient Unit in Elbasan than at the Surgery Inpatient Unit in Vlora. In Vlora, the mean length of employment was 131 months (range 6 – 264). In Elbasan, the mean length of employment was 172 months (range 72 – 396). Members of staff demographics, professional status, as well as length of experience is shown in the Table 11 below:

Table 11: General Hospitals Surgery Inpatient Unit Staff Demographic and Profession Related Data

	Vlora Regional Hospital Surgery Inpatient Unit	**Elbasan Regional Hospital Surgery Inpatient Unit**
Gender:		
Men	1	2
Women	5	5
Age:		
Mean Age	38.2 years	41.9 years
Standard Error of the Mean ($SE_{\bar{x}}$)	4.6	3.9
Age Standard Deviation	11.3	10.4
Length of Professional Experience:		
Mean Length of Professional Experience all staff	131 months	172 months
Standard Error of the Mean ($SE_{\bar{x}}$)	34.2 months	53.2
Length of Professional Experience Standard Deviation	83.9 months	130.2

SECTION 2: QUALITYRIGHTS THEMES/STANDARDS FINDINGS OF ALL HOSPITALS

This section includes the study findings related to all 4 hospitals. Section 2.1 presents a summary table of all 5 WHO QualityRights Toolkit Themes/Standards ratings across all 4 hospitals. A summary of all ratings is initially given in table 12.

Sections 2.2 – 2.6 present the findings related to each QualityRight Toolkit Theme/Standard in turn. Chapter IV, section 3.2 refers to the process via which interviews' qualitative data themes were identified. Illustrative quotes from participants are included where appropriate; a full list of quotes can be found in Appendix V.

2.1: SUMMARY OF ALL HOSPITALS RATINGS BASED ON WHO QUALITYRIGHTS TOOLKIT THEMES/STANDARDS

Table 12 presents a summary of all hospitals ratings based on WHO QualityRights Standards/Themes. The tables show individualized sub-ratings for each sub-standard of all 5 standards/themes; ratings will be elaborated in sections 2.2-2.6.

Table 12: Summary of WHO QualityRights Toolkit Ratings for all Hospitals

Facilities	Theme 1							Theme 2					Theme 3				Theme 4					Theme 5			
	The right to an adequate standard of living							The right to enjoyment of the highest attainable standard of physical and mental health					The right to exercise legal capacity, the right to personal liberty and security of person				Freedom from torture or cruel, inhumane or degrading treatment or punishment and from exploitation, violence and abuse					The right to live independently and be included in the community			
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	2.1	2.2	2.3	2.4	2.5	3.1	3.2	3.3	3.4	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4
"Ali Mihali" Vlora Psychiatric Hospital:	A/P	A/I	A/P	A/P	N/I	A/P	A/I	A/F	A/I	A/I	A/P	A/P	A/I	A/I	A/I	A/P	A/I	A/P	N/A	N/A	A/I	A/I	A/I	N/I	A/I
Overall Result:	**A/P**							**A/I**					**A/I**				**A/I**					**A/I**			
"Sadik Dinci" Elbasan Psychiatric Hospital:	N/I	N/I	A/I	A/P	N/I	A/I	A/I	A/F	A/I	A/I	A/P	A/I	A/I	A/I	A/I	A/P	A/P	A/P	N/A	N/A	A/P	A/I	A/I	N/I	A/I
Overall Result:	**A/I**							**A/I**					**A/I**				**A/P**					**A/I**			
Vlora Surgery Unit:	A/P	A/P	A/P	A/F	A/P	N/A	N/A	A/I	A/P	A/F	A/F	A/P	A/I	A/F	A/P	A/P	A/P	A/P	N/A	N/A	A/I	N/A	N/A	N/A	N/A
Overall Result:	**A/P**							**A/P**					**A/P**				**A/I**					**N/A**			
Elbasan Surgery Unit	A/P	A/P	A/F	A/F	A/P	N/A	N/A	A/P	A/P	A/F	A/I	A/F	A/I	A/F	A/P	A/P	A/P	A/P	N/A	N/A	A/I	N/A	N/A	N/A	N/A
Overall Result:	**A/P**							**A/P**					**A/P**				**A/P**					**N/A**			

A/F: Achieved in full
A/P: Achieved partially
A/I: Achievement initiated
N/I: Not initiated
N/A: Not applicable

2.2: QUALITYRIGHTS TOOLKIT THEME/STANDARD 1: "THE RIGHT TO AN ADEQUATE STANDARD OF LIVING" FINDINGS OF ALL HOSPITALS

QualityRights Toolkit Theme/Standard 1 is comprised of the sub-standards captured in Table 13 below:

Table 13: WHO QualityRights Toolkit Theme/Standard 1

Theme/Standard 1: The right to an adequate standard of living						
S: 1.1 The building is in good physical condition	**S: 1.2** The sleeping conditions of service users are comfortable and allow sufficient privacy	**S: 1.3** The facility meets hygiene and sanitary requirements	**S: 1.4** Service users are given food, safe drinking-water and clothing that meet their needs and preferences	**S: 1.5** Service users can communicate freely, and their right to privacy is respected	**S: 1.6** The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction	**S: 1.7** Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities

Table 14 summarizes all qualitative data themes identified for Theme/Standard 1 for all 4 study hospitals.

Table 14. WHO QualityRights Toolkit Theme/Standard 1 Qualitative Data Findings

Themes/Standards	**“Ali Mihali” Vlora Psychiatric Inpatient Unit** **N= 25**	**“Sadik Dinci” Elbasan Psychiatric Inpatient Unit** **N=25**	**Vlora Regional Hospital Surgery Inpatient Unit** **N=22**	**Elbasan General Hospital Surgery Inpatient Unit** **N=23**
QualityRights Theme/Standard 1				
Themes	**Mixed quality of living conditions, a daily reality**	**Indecent living conditions, a dreadful reality**	**Physical improvements of the hospital conducive to service user needs despite their limitations**	**Improved hospital environment and atmosphere yet not contemporarily compatible**
Subthemes	Decent bedroom conditions and indoors in newly built buildings Overcrowded chronic inpatient units as realities of inhumane living conditions Existence of bare life necessities, starting from kitchen conditions in chronic and sub-acute units Rundown rooms/washrooms/showers in chronic and sub-acute units	Overcrowding, a daily reality across all units Inadequate living conditions across all inpatient units Rundown rooms/washrooms/showers Safety concerns for staff and service users due to eruption of violence amongst service users	Post ‘90s renovations to address service gaps with limitations and caregiving implications for family members Unit damage by family members compromises service user quality of care Privacy improvements allow for more comfort amongst inpatients	Newly erected hospital and unit with service limitations Minimized room occupancy different from past history Freedom to choose and preference of home based essentials despite hospital supplies

	Violence amongst service users and lack of physical safety in overcrowded units			
Themes	**Infringement of personal freedom and privacy**	**Lack of personal freedom and privacy, a violation of rights**	**Service users freedom and supportive role of their family members as key factors in the service user recovery process**	**Service users freedom and supportive role of their family members as key factors in their recovery process**
Subthemes	Limited sense of freedom (movement, communication, choice) Mandatory clothing, a feature of inpatient units Lack of privacy in overcrowded units	Mandatory sleeping times Mandatory hospital clothing Lack of service user privacy Limited communication on the part of service users Limited movement within and outside inpatient units	Service user freedoms (movement with physical limitations, communication, choice of life essentials) contribute to quality of hospitalization Family members as key players in service user recovery process	Freedom of movement limited by physical limitation, as well as limited privacy, with freedom to communicate intact Family members as key players in service user recovery process
Themes	**Infringement of enjoyment of personal and social life, as grounds for action**	**Infringement of enjoyment of personal and social life, a significant life limitation**	N/A	N/A
Subthemes	Limited enjoyment of hospital based services, indoors and outdoors	Family abandonment Limited enjoyment of outdoor activities		

	Limited community engagement, depending on service user functionality Lack of family support and family abandonment Stigma (Service user, Family members, staff)	Limited enjoyment of indoor activities, with desirability for prolonged outdoor activities Stigma (Family member's), a reflection of internalized perceptions about their loved ones mental health state		

Specifically, WHO QualityRatings Toolkit Theme/Standard 1 ratings are captured in Table 15 below:

Table 15. WHO QualityRights Toolkit Theme/Standard 1 Ratings

Hospitals	Ali Mihali" Vlora Psychiatric Inpatient Unit	"Sadik Dinci" Elbasan Psychiatric Inpatient Unit	Vlora Regional Hospital Surgery Inpatient Unit	Elbasan General Hospital Surgery Inpatient Unit
Theme/Standard 1 Ratings	Achieved Partially (A/P)	Achievement Initiated (A/I)	Achieved Partially (A/P)	Achieved Partially (A/P)

Both psychiatric hospitals presented with a range of similarities and some differences with regard to this domain. There were separate rooms for males and females at both hospitals.

The "Ali Mihali" Vlora Psychiatric Hospital rated higher (A/P) than the "Sadic Dinci" Elbasan Psychiatric Hospital (A/I) due to the new buildings constructed in 2015 and better living conditions in the new buildings. However, these buildings accommodate the administration team and the acute service users, while all sub-acute and chronic service users continue to live in poor living conditions. Detailed illustrative quotes supporting each theme identified from interviews with all three study groups from all hospitals are found in Appendix: V.

Iron window bars were present in Elbasan, but not in Vlora. Separate units existed for male and female service users in both hospitals. Figures 11, 12, 13 and 14, below show the "Ali Mihali" Vlora Psychiatric Hospital premises, while Figures 15 and 16 show the outside of the "Sadik Dinci" Elbasan Psychiatric Hospital.

Figure 11. “Ali Mihali” Vlora Psychiatric Hospital Entrance

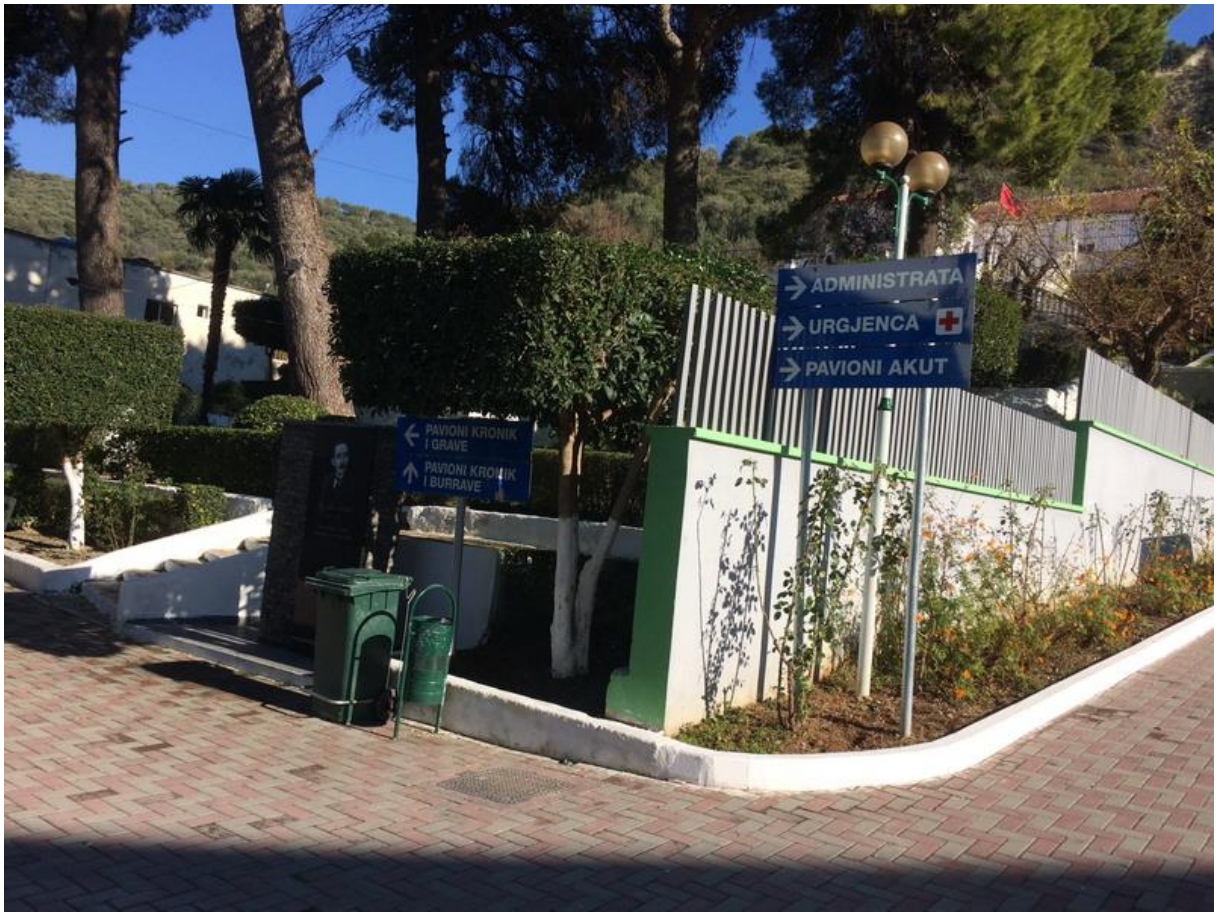

Figure 12. “Ali Mihali” Vlora Psychiatric Hospital Outdoors

Figure 13. “Ali Mihali” Vlora Psychiatric Hospital Women’s Chronic Building Front Area Where Residents Spend Their Outdoors Time

Figure 14. “Ali Mihali” Vlora Psychiatric Hospital – Newly Built Acute Ward Reception Area

Figure 15. “Sadik Dinci” Elbasan Psychiatric Hospital Entrance


Figure 16. “Sadik Dinci” Elbasan Psychiatric Hospital Outdoors – Back Side

Lack of funding was reported at both psychiatric hospitals. Figure 17 also shows the impoverished state of staff offices at the “Ali Mihali” Vlora Psychiatric Hospital below:

Figure 17. “Ali Mihali” Vlora Psychiatric Hospital Nursing Station in Chronic Units

With the exception of the newly built acute unit in Vlora whose furnishing, e.g., service user leisure area, beds, bedroom closet, was new and comfortable, in all other inpatient units in Vlora and Elbasan furnishing was inadequate and not comfortable.

Safety procedures were limited at both hospitals. With the exception of the newly built acute unit in Vlora which had fire exits and fire extinguishers on each floor, all other units in Vlora and Elbasan had a fire extinguisher whose operation was not regularly tested. No emergency policies or procedures were found should an emergency occur at either hospital.

Overcrowding was prevalent in all chronic units of the two hospitals, as well as in the sub-acute unit at the “Ali Mihali” Vlora Psychiatric Hospitals, with rooms occupied by 12+ service users, and the prevalence of violence amongst service users noted in both hospitals. A few of the service users during the visits appeared to be in bed (sleeping/sedated) even though it was not siesta time.

The following quotes speak to dissatisfaction with the living conditions at the “Sadik Dinci” Elbasan Psychiatric Hospital:

“Ten people in one room, I was much better off in my city…., I want to go back. It is all men, the majority of them are really mentally sick, they talk to themselves, even

at night, I can't sleep because of them, I want some peace, and I can't find it here……" (service user)

"Fights spread out pretty quickly and we have patients hurt, i.e., teeth broken, as well as staff hurt, i.e., hit on the head, or grabbed, we want to stop these fights asap" (staff member)

Figures 18 and 19 show psychiatric chronic unit bedroom conditions in Vlora and Elbasan respectively:

Figure 18. "Ali Mihali" Vlora Psychiatric Hospital, The Women's Chronic Inpatient Bedroom

Figure 19. “Sadik Dinci” Elbasan Psychiatric Hospital Chronic Unit Bedroom

In contrast to the impoverished state of the service user bedrooms in the psychiatric chronic units at each psychiatric hospital, Figure 20 and 21 below show examples of the indoor facilities, of the newly built acute unit at the “Ali Mihali” Psychiatric Hospital.

Figure 20. “Ali Mihali” Vlora Psychiatric Hospital Acute Unit Service User Bedroom

Figure 21. “Ali Mihali” Vlora Psychiatric Hospital Acute Unit Cafeteria

No air conditioning existed in these units at either hospital. Floor temperatures were reported as cold in the “Sadik Dinci” Elbasan Psychiatric Hospital, and in the chronic and sub-acute units at the “Ali Mihali” Vlora Psychiatric Hospital. Overall it was stated that the floor temperature in all the old buildings was poor, except for the acute units in Vlora. The quotes below speak to these reported concerns:

“We’ve got no heating in our room. It’s so cold and dark in the room. The light bulb in the middle of the room does not work. Not fixed yet… I go to the front of the building to warm up a bit, when it is sunny like today… I cover my head with the blanket when I go to my room. So do my other roommates” (service user at the “Ali Mihali” Vlora Psychiatric Hospital)

“It is winter and cold outdoors, but it is warm and comfortable indoors, which I like” (service user at the new building at the “Ali Mihali” Vlora Psychiatric Hospital)

The poor state at the “Ali Mihali” Psychiatric Hospital is captured in Figure 22 while Figure 23 shows the state at the “Sadik Dinci” Elbasan Psychiatric Hospital below:

Figure 22. “Ali Mihali” Vlora Psychiatric Hospital, the Women Chronic Inpatient Unit Hallway

Figure 23. “Sadik Dinci” Elbasan Psychiatric Hospital Hallway in Male Chronic Unit (unit doors are locked)

Service users in both hospitals reported dissatisfaction with shower conditions due to lack of renovations and functionality issues, as well as lack of doors in WCs and showers. This feedback did not apply to the new acute ward buildings at the Vlora Psychiatric Hospital as seen in Figure 24 below:

Figure 24. “Ali Mihali” Vlora Acute Unit Psychiatric Hospital Washroom/Shower

Figure 25 – 28 below reflect the impoverished state of washrooms and showers at the “Ali Mihali” Vlora Psychiatric Hospital (old buildings) and “Sadik Dinci” Elbasan Psychiatric Hospital.

Figure 25. “Ali Mihali” Vlora Psychiatric Hospital Service Chronic User Unit Shower

Figure 26. “Ali Mihali” Vlora Psychiatric Hospital Chronic Service User Unit Shower

Figure 27. “Ali Mihali” Vlora Psychiatric Hospital Chronic Service User Washrooms

28. “Sadik Dinci” Elbasan Psychiatric Hospital Chronic Service User Showers

In both hospitals, service users and staff reported that service users take mandatory showers once per week as per a pre-determined weekly schedule decided by staff. There were service users who reported they can take showers more than once

a week if they wished to do so and they had access to soap and water. No towels or toilet paper was seen in washrooms in either hospital. Toilet paper was seen in the new buildings only at the “Ali Mihali” Vlora Psychiatric Hospital. Soap was available in washrooms at both hospitals. The washroom/showers state is reflected in the quote from a family member at the “Sadik Dinci” Elbasan Psychiatric Hospital who stated:

“I have seen the showers once, they look like prison showers, next to one another with just some broken dividers in between. ….all women, but still…..”

In addition, the impoverished state of kitchen areas at both psychiatric hospitals is seen in Figures 29 – 32 below:

Figure 29. “Ali Mihali” Vlora Psychiatric Hospital Chronic Service User Unit Kitchen

Figure 30. “Ali Mihali” Vlora Psychiatric Hospital Chronic Service User Unit Kitchen

Figure 31. “Sadik Dinci” Elbasan Psychiatric Hospital Male Chronic Unit Eating Area and Leisure Area

Figure 32. “Sadik Dinci” Elbasan Psychiatric Hospital Chronic Unit Hallway into the Eating Area

Presence of basic essentials, e.g., bedding and food was reported in both hospitals. Food was outsourced to external companies; in both hospitals most service users said it was of good quality, with some reservations at the “Ali Mihali” Vlora Psychiatric Hospital. Both hospitals appeared to have planned menus which included nutritious well-balanced meals, with accommodations made for service users with particular dietary issues subject to medical conditions only, e.g., diabetes. At the “Sadik Dinci” Elbasan Psychiatric Hospital recreation centre, there was access to a kitchen for occupational therapists and service users which meant they could cook and have meals from time to time in this centre. Meal times were all scheduled and service users had 3 meals at pre-determined times. Except for the acute service user buildings, in all other units in both hospitals service users had access to drinking tap water after the meal times in the washrooms.

Infringements of personal freedom and privacy was noted in both hospitals. Service users had to wear mandatory hospital clothing; their clothes were donated by donors and they appeared dressed appropriately for winter but not according to their preferences, i.e., personal clothing was prohibited. Figures 33 and 34 below show supplies of clothes provided to service users.

Figure 33. “Ali Mihali” Vlora Psychiatric Hospital Spare Winter Clothing for Service Users

Figure 34. “Ali Mihali” Vlora Psychiatric Hospital Spare Winter Clothing for Service Users

The quote below speaks to living limitations at the “Sadik Dinci” Elbasan Psychiatric Hospital.

“I’ve brought him his home clothes, but the nurse says he does not need them. Not sure why…” (family member)

All three study groups: service users, members of staff and family members referred to service user lack of privacy in all units. The quotes below, excerpted from the qualitative data collected at “Sadik Dinci” Elbasan Psychiatric Hospital, speak to these limitations.

“Privacy is a word that does not apply to such places” (staff member)

“I can’t lock or secure anything that my mother brings me ….” (service user)

Interview qualitative data showed that the newly built acute unit at the “Ali Mihali” Vlora Psychiatric Hospital is more conducive to active participation and interaction of service users than the chronic inpatient units at the same hospital and at the “Sadik Dinci” Elbasan Psychiatric Hospital.

Figures 35 – 36 below show the outdoors as well as the occupational room area which service users spend time in at the “Sadik Dinci” Elbasan Psychiatric Hospital.

Figure 35. “Sadik Dinci” Elbasan Psychiatric Hospital Backyard Area Where Service Users Spend Some Time Outdoors

Figure 36. The “Sadik Dinci” Elbasan Psychiatric Hospital Occupational Room/Oupatient Centre

Infringements relating to enjoyment of life, both personally and socially were identified in both psychiatric hospitals. Service users at both hospitals were allowed to use the grounds during scheduled times but were accompanied by members of staff at all times. Service users in both hospitals expressed a desire to spend longer times outdoors and engage in meaningful recreational activities, e.g., going on trips (which some of them stated they had done), as well as spending longer times at the outpatient centres/occupational rooms. A lack of staffing resources to accommodate such requests were reported by staff in both hospitals. These limitations are illustrated via quotes indicated below:

“Staff members do not let me spend much time outside. I don’t know why” (service user at the “Sadik Dinci” Elbasan Psychiatric Hospital)

“A lot of our routines are regimented, our new director has introduced a lot of strict control” (staff member at the “Sadik Dinci” Elbasan Psychiatric Hospital)

Similarly, the quote below from the “Ali Mihali” Vlora Psychiatric Hospital, speaks to the limited enjoyment of life in this hospital on the part of service users.

“I don’t go outside the hospital much. I have Turkish coffee at Turi’s Caffee. Staff members take us there and I love it. I have been by the seaside. It is so nice” (service user)

Service users in the newly built acute unit at the “Ali Mihali” Vlora Psychiatric Hospital reported enjoying spending time in the newly built occupational centre and the fitness room. These units serve just 34 acute service users out of all 144 hospital service users. Figure 37 shows the fitness room in the newly built units, whereas Figure 38 shows the occupational/leisure room in the chronic service unit at the same hospital.

Figure 37. “Ali Mihali” Vlora Psychiatric Hospital Gym in the New Building (Acute Unit)

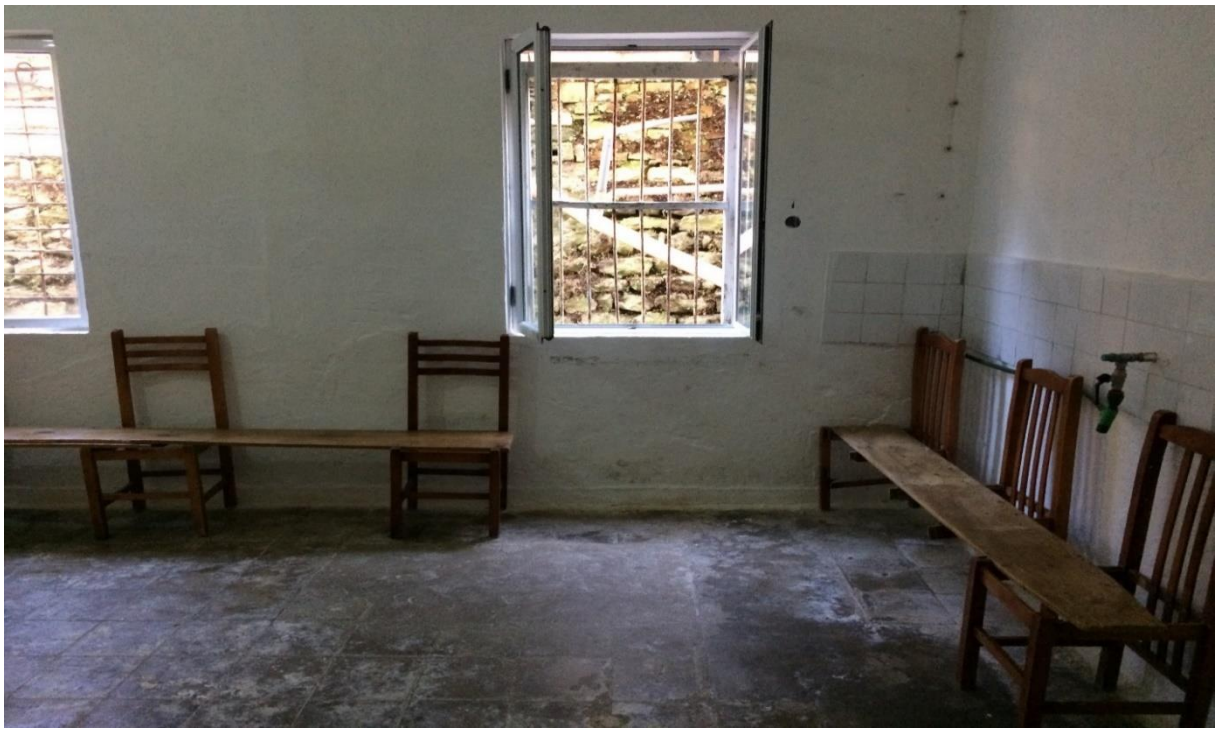

Figure 38. “Ali Mihali” Vlora Psychiatric Hospital Service User Leisure Activities Room

Family abandonment, a factor affecting service user enjoyment of life, was also reported by all study groups at both hospitals, as reflected in the quotes below:

"A lot of chronically ill patients are completely abandoned for years by their family members" (staff member at the "Ali Mihali" Vlora Psychiatric Hospital)

"No one takes me home. My family members have not seen me for a long time" (service user at the "Ali Mihali" Vlora Psychiatric Hospital)

In addition, stigma as another factor affecting service user enjoyment of life was identified in both psychiatric hospitals. The quotes below illustrate reported stigma on the part of family members.

"Bringing your child to a psychiatric hospital, is the nightmare of any parent, I would imagine. It means your child is crazy….that's what people think….." (family member at the "Ali Mihali" Vlora Psychiatric Hospital).

"I guess staff find it difficult having so many crazy patients in one place" (family member at the "Sadik Dinci" Elbasan Psychiatric Hospital).

The poster captured in Figure 39 below shows staff efforts to address mental health stigma at the "Sadik Dinci" Elbasan Psychiatric Hospital:

Figure 39. "Sadik Dinci" Elbasan Psychiatric Hospital Visiting Hours and Anti-Stigma Poster
(Poster content translation: We should not feel ashamed of mental illness. We should feel ashamed of stigma and prejudices, Bill Clinton).

There is a stark contrast between the Psychiatric Hospitals and the Surgery Inpatient Units at general hospitals in Vlora and Elbasan respectively. With regard to WHO QualityRights Toolkit Theme/Standard 1: “The right to an adequate standard of living”, both Surgery Inpatient Units in Vlora and Elbasan rated as: Achieved Partially (A/P) which reflects the physical building improvements made in these units as a result of funding from the Albanian government as well as international donors. The Surgery Inpatient Unit in Vlora Regional Hospital was entirely renovated, meanwhile, the Surgery Inpatient Unit at the Elbasan General Hospital was newly built and replaced the old Surgery Unit in the same hospital. Interview data spoke to funding availability to carry out renovations of the Surgery Inpatient Unit in Vlora and to construct the Surgery Inpatient Unit in Elbasan. Figures 40 – 42 show photos of the renovated regional hospital in Vlora and Elbasan:

Figure 40. Vlora Regional Hospital Main Entrance

Figure 41. Vlora Regional Hospital Main Entrance (Indoors
(Wall poster content makes reference to European Commission donations made to this hospital. No smoking allowed. CTV in use)

The renovated waiting area in the Surgery Inpatient Unit in Vlora in Figure 42 below speaks to the marked contrast with the psychiatric unit in Vlora.


Figure 42. Vlora Regional Hospital Surgery Inpatient Unit Waiting Area

On the other hand, Figure 43 below shows the newly built Elbasan General Hospital building where the Surgery Inpatient Unit is located.

Figure 43. Elbasan General Hospital Main Campus

This newly built building replaced the old hospital building and its premises which is captured in Figure 44 and 45 respectively below:

Figure 44. The Old Surgery Unit in Elbasan Which Was Replaced by the New Surgery Unit

Figure 45. The Old Surgery Unit Service User Washroom in Elbasan Regional Hospital

Presence of spacious elevators which accommodated wheelchairs was noted in both hospitals. Both units in Vlora and Elbasan lacked a sprinkler system and had a fire extinguisher which had not been checked. No policies in case of emergency were noted. Service users and their family members spoke to the poor quality of building materials used indoors, e.g., wall plaster in Elbasan.

There were separate rooms for males and females which were all air-conditioned. Children under the age of 15 were placed in women's rooms. Room occupancy was 1-4 service users in both Surgery Inpatient Units in Vlora and Elbasan and no privacy dividers existed in these rooms. All three study group participants spoke to the improvements made in these units in the last 20 years. Despite these improvements, patient beds lacked monitoring bed head panels in both units. Figures 46 – 48 show Surgery Inpatient Unit conditions in Vlora and Elbasan respectively below:

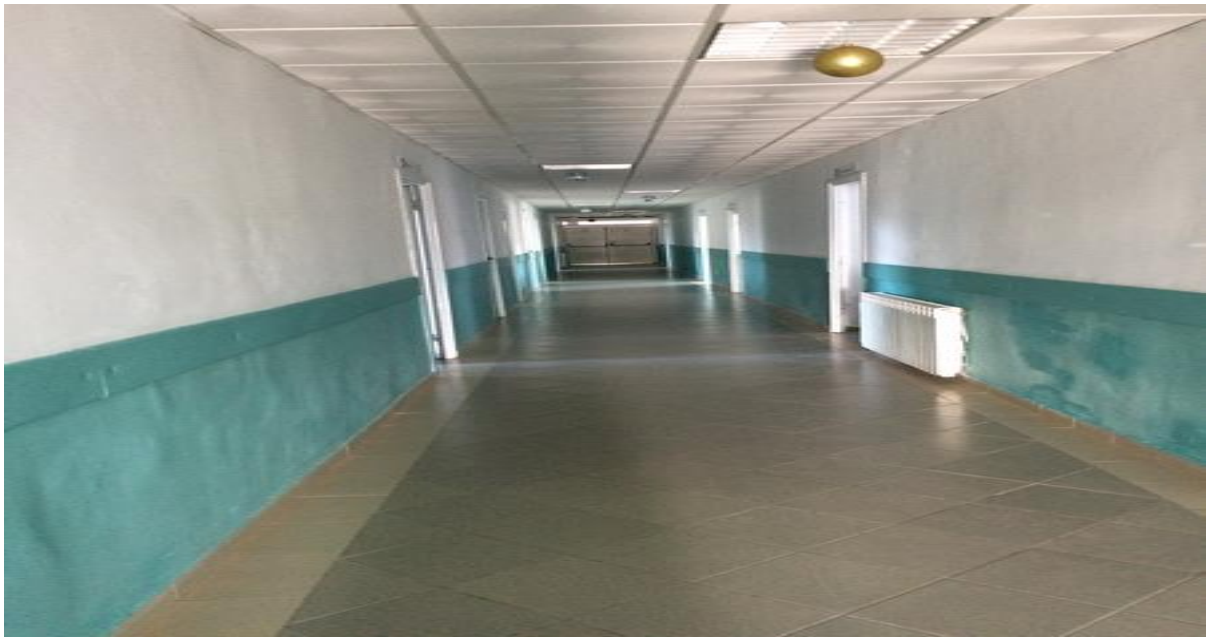

Figure 46. Vlora Regional Hospital Surgery Unit Hallway

Figure 47. Vlora Regional Hospital Surgery Unit Service User Room Bed without a Monitoring Head Panel

Figure 48. Elbasan General Hospital Surgery Unit Service User Room

These improvements were seen in the nursing stations at both hospitals as seen in Figure 49 below:

Figure 49. Elbasan General Hospital Surgery Unit Nursing Station

Figures 50 and 51 below speak to the improved state of service user/showers at both surgery units. Ensuite showers/washrooms exist at the Surgery Inpatient Unit in Elbasan. All washroom/shower related supplies were available in both surgery units and service users reported they could take showers on an as per need basis.

Figure 50. Vlora Regional Hospital Surgery Unit Service User Shower

Figure 51. Elbasan General Hospital Surgery Unit Service User Washroom

The difference in rating between two surgery units was attributed to functionality issues of showers at the Surgery Inpatient Unit in Vlora as reported by service users. On the other hand, members of staff complained of unit damage by family members which compromises service user quality of care.

Presence of basic essentials, e.g., bedding and food were reported in both hospitals in Vlora and Elbasan. Freedom to bring any home based supplies, e.g., bedding sheets, food, clothing, was reported contrary to the lack of similar freedom in the psychiatric units. Food was outsourced to external companies geared to meet the needs of surgery unit patients.

All three study groups indicated service user freedom to communicate freely was subject to the service users' physical condition. Lack of service user room privacy dividers informed the rating of this as sub-standard. In addition, both surgery units displayed their visiting hours and their admission criteria as captured in Figure 52 below, even though staff member feedback indicated that such hours were not respected by family members.

Figure 52. Vlora Regional Hospital Service Hours Posted at the Hospital Entrance
(Poster content translation: Physician Consults; Lab tests; Receiving hours of all lab tests; Family Members Visiting Hours; Necessary Documentation for Admission: GP's Referral and the Health Card)

Contrary to the surgery units where the service users appeared to have a family member present at all times, family abandonment was noted in the psychiatric hospitals in Vlora and Elbasan.

Illustrative quotes pertaining to all sub-standards are captured in Appendix V. The assessment committee did not assess sub-standard 1.6 and 1.7 due to their lack of relevance to surgery units.

In conclusion, the “Sadik Dinci” Elbasan Psychiatric Hospital, and the “Ali Mihali” Vlora Psychiatric Hospital chronic service user units appeared to offer inhumane living conditions, except for the newly built acute buildings at the “Ali Mihali” Vlora Psychiatric Hospital, whereas the buildings and facilities at the Surgery Units at both General Hospitals were of a better standard. Significant service user freedom limitations and family abandonment were noted in the psychiatric units.

2.3: QUALITYRIGHTS TOOLKIT THEME/STANDARD 2: "THE RIGHT TO ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH" FINDINGS OF ALL HOSPITALS

Theme/Standard 2 is comprised of the sub-standards captured in Table 16 below:

Table 16: WHO QualityRights Toolkit Theme/Standard 2 Sub-standards

Theme/Standard 2: The right to enjoyment of the highest attainable standard of physical and mental health				
S: 2.1 Facilities are available to everyone who requires treatment and support	**S: 2.2** The facility has skilled staff and provides good-quality mental health services	**S: 2.3** Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community	**S: 2.4** Psychotropic medication is available, affordable and used appropriately	**S: 2.5** Adequate services are available for general and reproductive health

Table 17 summarizes all qualitative themes identified for Theme/Standard 2 for all 4 study hospitals.

Table 17: WHO QualityRights Theme/Standard 2 Qualitative Data Findings

Standards/Themes	**“Ali Mihali” Vlora Psychiatric Hospital** **N= 25**	**“Sadik Dinci” Elbasan Psychiatric Hospital** **N=25**	**Vlora General Hospital Surgery Inpatient Unit** **N=22**	**Elbasan General Hospital Surgery Inpatient Unit** **N=23**
QualityRights Theme/Standard 2				
Themes	**Voluntary and involuntary admissions key features of admission process**	**Easy access to hospital care, despite other service limitations**	**Pathways and challenges in order to access hospital care**	**Pathways and challenges in order to access hospital care**
Subthemes	Reported challenges regarding both voluntary and involuntary admissions cases Admissions based on broad inclusion criteria, including hosting people with intellectual disabilities	Inclusion criteria as a determining factor regarding access to care Compromised care due to staff shortage and lack of funding Rapid access to physicians consults Adequate supplies of free medication with partial education on side-effects Partial health promotion activities	Family physician referrals and emergency service as points of admission to surgery unit Surgeons’ extortion schemes as barriers to access to care Staff attitude valued in service user recovery Comprehensive examination and care once admitted Medication availability meets service user needs	Family physician referrals and emergency service as point of admission to surgery unit Quality of care contingent upon staff expertise/experience and willingness to serve well Comprehensive examination and care once admitted Lack of hospital medication a barrier to recovery and a financial burden to patient’s family Physicians, as key determinants of patient treatment process

			Physicians, as key determinants of patient treatment process	
Themes	**Variable quality of care in a predominantly institutionalized and medically oriented model of care**	**The medical model and patient institutionalization as the main treatment model**	**Limited awareness of service user human rights despite anti-corruption and service quality improvement efforts on the part of the government**	**Anti-corruption efforts of government aim to protect service user rights**
Subthemes	Mixed quality staff responsiveness and attitude (access to physicians and others) Long standing hospitalization impacts treatment Staff shortage as a barrier to quality of care Availability of medication and health services and partial counsel on their role Limited health promotion and reproductive health education	Treatment with medication as determined by psychiatrists is the main form of treatment Partial psychosocial treatment available Long standing history of crowded institutionalization of service users Staff knowledgeable about limited community and recovery based resources Partial compliance with documentation guidelines	Limited knowledge of patient rights including limited service user feedback solicitation practices Anti-corruption and service quality improvement efforts on the part of the government	Limited knowledge of patient rights including limited service user feedback solicitation practices Intensified government efforts to increase patient protection in health care affects staff performance Past system influences, along with expectations about staff knowledge of such rights

	Partial compliance with documentation guidelines			
Themes	**Lack of knowledge of CRPD and limited knowledge of service user rights**	**Lack of knowledge of CRPD and limited knowledge of service user rights**	**Staff dissatisfaction**	**Moderate knowledge of service user rights**
Subthemes	Lack of knowledge of CRPD Lack of and/or limited knowledge of service user rights Presence of mechanisms to attend to service user rights	Limited range of mechanisms for service users to express an opinion Service users and family members depending on staff to know users' rights Legacy of past isolation on understanding of human rights	Staff rights infringement and violence against staff Staff fear of being watched	Lack of knowledge of CRPD Knowledge of service users rights to care, being free of abuse Limited range of mechanisms for service users to express an opinion
Themes	**Stigma, a quality of life deteriorating factor**	**Stigma, a quality of life deteriorating factor**		**Staff dissatisfaction**
Subthemes	Stigma (Family member's)	Internalized stigma Stigma (staff's and family members')		Staff rights infringement and violence against staff Staff fear of being watched
Themes		**Staff dissatisfaction, a prevalent sentiment**		
Subthemes		Lack of staff rights Violence against staff Staff fear of repercussions		

Both psychiatric hospitals rated as Achievement Initiated (A/I) in this standard. Theme/Standard 2 ratings are captured in Table 18 below:

Table 18. WHO QualityRights Toolkit Theme/Standard 2 Ratings

Hospitals	Ali Mihali" Vlora Psychiatric Inpatient Unit	"Sadik Dinci" Elbasan Psychiatric Inpatient Unit	Vlora Regional Hospital Surgery Inpatient Unit	Elbasan General Hospital Surgery Inpatient Unit
Theme/Standard 2 Ratings	Achieved Initiated (A/I)	Achieved Initiated (A/I)	Achieved Partially (A/P)	Achieved Partially (A/P)

Both psychiatric hospitals follow the same admissions criteria based on admission pathways (catchment area; referral from the GP, a specialist physician of the district; emergency room) which is pre-determined by their funder. They also admit people with intellectual disabilities, even in the absence of a mental health condition on their part, due to lack of housing for these service users in other sectors.

The following quote from the "Sadik Dinci" Elbasan Psychiatric Hospital speaks to level of service accessibility:

"No one wants to be here for the most part, nor do we want to keep patients who don't meet our inclusion criteria" (staff member)

In addition, the data showed that both voluntary and involuntary admissions are a key theme for both hospitals, involuntary admissions being smaller in prevalence than the voluntary admissions. Neither hospital released data on the number of involuntary admissions although a number of service users, who had consented in writing for their admission within the first 48 hrs of their stay at the hospital, reported that they were being held against their will. Standard 3 findings will further address voluntary and involuntary admission cases, but this phenomenon is illustrated by the quote below:

"I have not had a problem getting help here. My problem is I don't want to be here. Entering this place, I think, is not a problem, leaving this place, is a problem. I don't understand why they keep me here" (service user at the "Ali Mihali" Vlora Psychiatric Hospital)

Furthermore, although it appeared that access to care in both hospitals appeared to be easy to pursue, quality of care in both hospitals was variable. Shortage of staff serving a high number of service users at the time (325), was observed to be an factor directly influencing the quality of care, particularly at the

“Sadik Dinci” Elbasan Psychiatric Hospital, e.g., occupational therapy services are available on a limited basis due to staff shortages at these hospitals. At the “Ali Mihali” Vlora Psychiatric Hospital, there was feedback that not all physicians are trained in the field of psychiatry, including nurses, which impacts their quality of care offered. Roles and responsibilities of members of staff were posted on walls. Service user occupational activities were also posted. Figures 53 - 54 below show member of staff responsibilities and service user occupational schedule activities respectively:

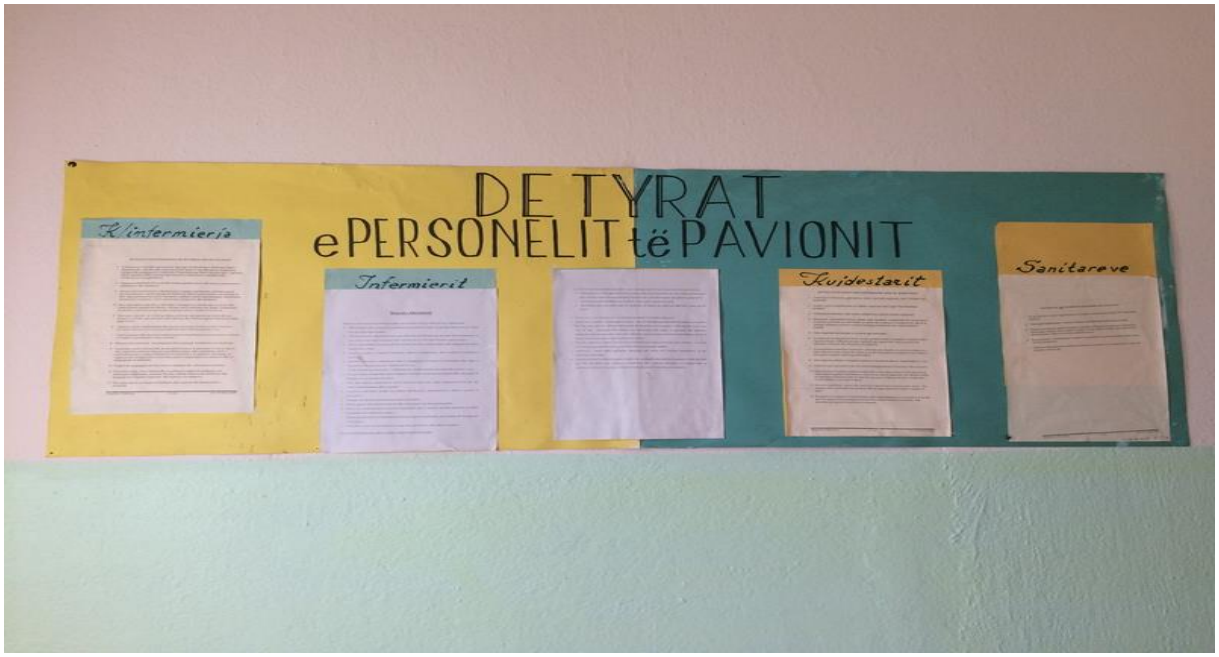

Figure 53. “Ali Mihali” Vlora Psychiatric Hospital Staff Responsibilities (Chief of Nursing, Nursing, Personal Support Worker, Housekeeping)

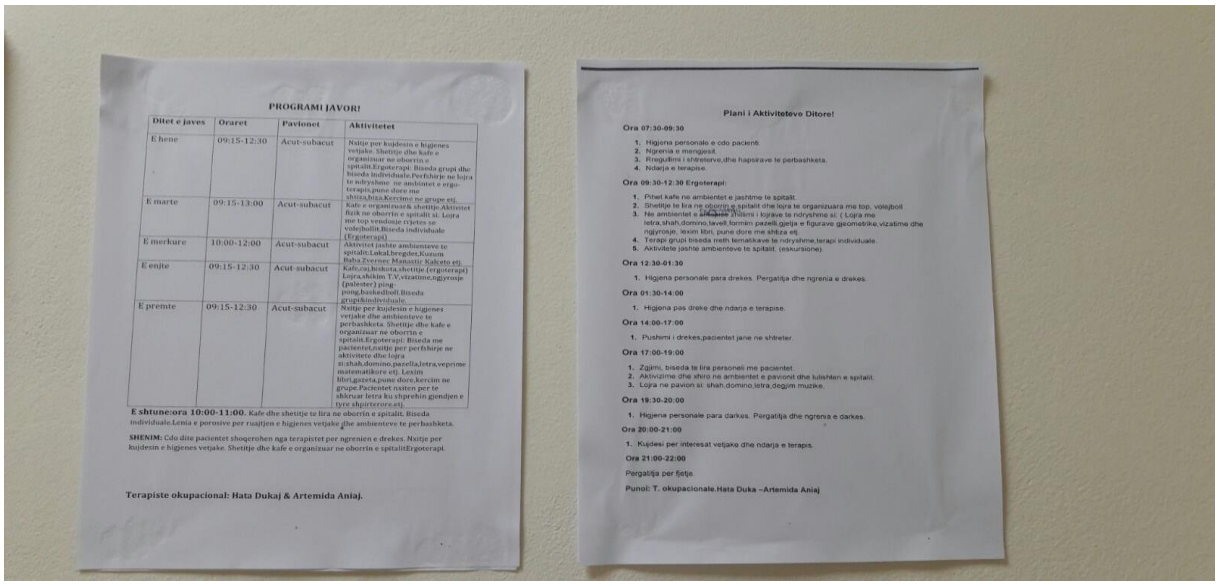

Figure 54. “Ali Mihal’ Vlora Psychiatric Hospital Occupational Therapy Schedule (Weekly Schedule; Daily Schedule of Occupational Therapy Activities)

Pertinent qualitative themes are reflected in quotes below:

"They complain they have a staffing shortage though, which could be the case. Shouldn't the government do something about this?" (family member at the "Sadik Dinci" Elbasan Psychiatric Hospital)

"We have 1 psychiatrist per 100 patients in this hospital, which is insufficient" (staff member at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Rehabilitation services at the "Sadik Dinci" Elbasan Psychiatric Hospital are offered on a scheduled basis at the two recreation centres established inside the hospital. These include activities such as life skills/cooking and art work, for service users who are deemed capable of attending on a once per week basis, with few recreational activities offered in these units. In addition, only a limited number of service users can access psycho-social group therapy.

Similarly, at the "Ali Mihali" Vlora Psychiatric Hospital, service users attend individual and group therapy if they are acute service users. The extent to which chronic service users are exposed to psychosocial activities appeared to be much less than acute service users due to the length of their stay in these hospitals. No single service user indicated he/she is aware of recovery based plans. No evidence-based/good practice service delivery models seemed available and staff spoke about lack of training in this direction, including lack of standardized intervention modalities, in addition to staff shortage to respond to needs of all service users: acute, sub-acute, chronic, with intellectual disabilities.

These findings are further supported with the quotes below:

"There are male patients in chronic units who have been here since 1984, and females in chronic female units since 1981. You can't expect progress for people who have been here that long…such hospitals were used as punitive places in the past system…." (staff member at the "Ali Mihali" Vlora Psychiatric Hospital)

"…..recovery plans are not always complete, we have a long way to go….we do ask patients what they wish to do…but there is not enough time and staff to dedicate a lot of attention to one patient" (staff member at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Similarities were seen regarding the main form of treatment offered at both psychiatric hospitals. All staff reported that medical treatment is the main form of treatment as determined by the attending physician with input from psycho-social staff. There was evidence in two files at the "Sadik Dinci" Elbasan Psychiatric Hospital of attending psychiatrists referring service users with need for extensive medical treatment to the Elbasan General Hospital for further examinations and treatments.

The quote below speaks to the main form of treatment:

"……pharmacological treatment remains at the heart of the treatment plan" (staff member at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Lack of service user choice in their recovery process along with a series of limitations, e.g., clothing, complying with siesta time, etc., impacts quality of care and recovery for service users. Observation of service user files showed that although treatment plan templates existed in both hospitals, they were not consistently completed and kept up-to-date. Only 1 out of 12 files of chronic service users was completed at the "Sadik Dinci" Elbasan Psychiatric Hospital. When information was present in files, it captured service user diagnosis (missing in a few files), medication administered, and core recreation activities they engage in if attending the recreation centre. Similarly, at the "Ali Mihali" Vlora Psychiatric Hospital, none out of 13 files were complete. 3 out of 13 had treatment plans but lacked completion of progress notes, including routine tests and occupational therapy activities undertaken with service users.

Limited health promotion activities were reported at both hospitals, however, no such promotion was documented in service user files. In addition, despite anti-smoking posters posted at both hospitals, staff and service users smoked in both hospitals. The difference is that staff and service users smoked outside the buildings at the "Ali Mihali" Vlora Psychiatric Hospitals, while staff and service users smoked both inside and outside the hospital units at the "Sadik Dinci" Elbasan Psychiatric Hospital including in the offices of the management team, despite service user feedback that some of them were bothered by the presence of smoking, as illustrated in the following quotes:

"There are 8 other guys in my room. They all smoke, I don't, I mean I end up smoking their smoke, as they all smoke. It makes me sick…" (service user at the "Sadik Dinci" Elbasan Psychiatric Hospital)

"Health promotion is done depending on season, needs, etc, i.e., winter for flu shots, patient needs, i.e., healthy diets for diabetic patients, etc." (member of staff at the "Ali Mihali" Vlora Psychiatric Hospital)

"My doctor has told how harmful taking cocaine is for my health. I did not think that way when I used cocaine though. I have changed my mind about it now. I guess any substance is not good for the health" (service user at the "Ali Mihali" Vlora Psychiatric Hospital)

In addition, both hospitals appeared to have guidelines regarding the frequency of medical examinations service users have to undergo: upon admission, every 6 months, including blood work conducted monthly as well as other tests, e.g., X-rays, which staff indicated occurred every 6 months, and other tests related to specific medical conditions. However, files indicated lack of consistency in complying with such documentation guidelines and it remains unknown if routine examinations occurred as planned.

"We offer general check-ups ups every 6 months, an initial check-up at the time of admission and on an as per need basis by doctor orders. Blood work is done once a month" (staff member at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Differences between the two hospitals were noted regarding awareness of service user rights at both hospitals. There was a wall plaque at the "Ali Mihali" Vlora Psychiatric Hospital referring to the role of the People's Ombudsman office in monitoring protection of service user rights in this hospital. In addition, there was an anti-corruption sign posted in the main reception of the new building, as seen in Figure 55 below:

Figure 55. "Ali Mihali" Vlora Psychiatric Hospital – Anti Corruption Poster
(Poster content translation: Corruption is a crime against life. Do NOT take, solicit, give bribes. Please call us at the number below to denounce it).

No formal mechanism, i.e., quality of care assessment, was found to capture service user experience, including services users with intellectual disability while under hospital care. There were client satisfaction questionnaires provided by the funder, but which were not customized for the psychiatric setting and did not relate to the array of services offered in this hospital. No forms appeared completed in the feedback box. In both hospitals, meeting times of hospital directors with the public were published, yet, no information on the role of the Ombudsman nor any anti-corruption poster existed at the "Sadik Dinci" Elbasan Psychiatric Hospital.

No evidence was found either from interviews or from reviewing the service user files and other relevant documents on how any party feedback was incorporated in the treatment plan of the service user. Family members indicated they are not aware

of a formal mechanism to express their views on the quality of care their loved ones receive. They stated they would consider speaking to the director of the hospital and/or attending physician if need be, and two family members at the “Ali Mihali” Vlora Psychiatric Hospital and at the “Sadik Dinci” Elbasan Psychiatric Hospital respectively indicated they had done so.

At the “Sadik Dinci” Elbasan Psychiatric Hospital a service user stated:

“….staff will not let me speak to the director... I want to tell the director I want to leave. They must want to keep me here”

At both psychiatric hospitals, no service user rights information was available anywhere. All staff reported a lack of knowledge with regard to CRPD as well as expressed limited knowledge of service user rights. They stated they are aware of hospital policy which speaks to provision of care that is free from abuse and informed consent in voluntary admission cases. They stated they are less aware of other human rights with respect to the rights of service users to access of information and their duty to inform service users about treatment options. There were service users at both hospitals who said they would speak to the Chief of Nursing and the physicians if they wished to express an opinion, yet with reservations as three of them believed their input would be held against them. A family member who refused to provide consent due to fear of reprisal against this person’s loved one who was receiving treatment at the “Sadik Dinci” Elbasan Psychiatric Hospital, stated the assessment committee members should carefully observe what occurs at that hospital.

Illustrative quotes below support the above-stated indications:

“As for my son’s rights, I don’t know what these rights are while he is here. I would assume he must be treated like a human being while he is here” (family member at the “Ali Mihali” Vlora Psychiatric Hospital)

“I have never heard of CRPD myself. We have had some training on patient rights and there are professional codes of conduct expected through the licensing body of our professions in which we are to treat patients respectfully and provide the best care we can deliver” (member of staff at the “Sadik Dinci” Elbasan Psychiatric Hospital)

“Even if there was a lot of information on patient rights, I don’t know if members of staff would so easily change. Lack of compassion regarding the vulnerable people is ingrained in our culture and change is hard when you have been isolated for so long” (family member at the “Sadik Dinci” Elbasan Psychiatric Hospital)

Although no assessment of appropriateness of medication administered was conducted due to the limited expertise of the assessment committee in this domain, all medication service users were treated with was present in the files, with the exception of 1 service user file which lacked such documentation. Consistency in documenting administration of medication daily was fragmented across all files at both hospitals, e.g., members of staff indicated they administer the medication daily, yet, 1/3 of all files in both hospitals lacked written documentation of this process.

In addition, there was some evidence in both hospitals of service users being informed of the side effects of the medication they were on and service user interviews partially supported this finding. There was no evidence of application of advance directives, including lack of knowledge of advance directives on the part of service users and members of staff.

The following quotes illustrate the above-stated findings:

"I take the medication I am given, it's not much, I don't pay for it, I have no money…" (service user at the "Sadik Dinci" Elbasan Psychiatric Hospital)

The "Ali Mihali" Vlora Psychiatric Hospital has banned smoking within its buildings, differently from the smoking practices at the "Sadik Dinci" Elbasan Psychiatric Hospital. On the other hand, data collected showed lack of reproductive health education at both hospitals. This finding is illustrated with the quote below:

"I don't recall us offering any reproductive health education, at least not for the chronic patients…" (member of staff at the "Ali Mihali" Vlora Psychiatric Hospital)

Stigma was identified as a key qualitative data theme finding, amongst all three study groups. Internalized stigma was noticed amongst service users, while externalized stigma was seen amongst family members and members of staff, as seen in the following quotes:

"I don't want many people to know about me being sick, as when I get back home they will think poorly of me" (service user at the "Sadik Dinci" Elbasan Psychiatric Hospital)

"…advanced directives, I don't know what they are. They are not applied here. They don't get applied with normal people, let alone with psychiatric patients" (member of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital)

In addition, all 7 members of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital reported dissatisfaction with lack of protection of their rights in the workplace, in terms of policy as well as practice. Similar feedback was collected in Vlora, and staff indicated they are penalized monetarily if they do not intervene to diffuse the service user fights and protect hospital property; the cost of furniture replacement is deducted from their monthly salary.

They stated that a lack of budget prevents the hospital from hiring security staff who are specialized in dealing with physical fights amongst service users in the hospital. Staff referenced the overcrowding conditions of the units which make it difficult to de-escalate physical fights between service users. The quote below speaks to members of staff feedback about their employment conditions:

"I want to hear about a CRPD for staff too, and what can be done to increase our salaries, which are ridiculous…" (member of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Members of staff expressed reservations about the use of the information collected from them because of the risk it could jeopardize their employment status if their identity was revealed. This is captured in the quote below:

"I trust you will treat this information as you said you would, as I don't want to lose even this job. I have decided to answer your questions as you are not with the media and you are not recording this interview. It is quite difficult getting any jobs here…" (member of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Last, members of staff in both hospitals were aware of community resources e.g. KEMP's (disability) office, housing services, although they indicated that these were scarce in nature and difficult to collaborate with without physically accompanying services users.

In contrast to the psychiatric services, the surgery unit in Vlora presented access to care challenges. Two service users at the "Vlora General Hospital" indicated they are paying the admission surgeon at the emergency room a tip (bakshish – in Albanian) as a condition of admission even though admission criteria were posted at both hospitals. Study participants did not reveal the amount paid due to fear of reprisal on the part of surgeons, but made reference to the 'tip range typical for surgery units'.

At both surgery units, service users and their family members linked quality of care with staff length of experience as well as staff attitudes towards caring for service users. They expressed their disappointment regarding ongoing physician extortion schemes in public hospitals. Service user and family member feedback spoke highly of nursing members of staff at both hospital, particularly at the "Elbasan General Hospital".

Unlike the psychiatric hospitals, feedback from service users and their family members at both surgery units, stated that family members play a key role in the decision making process of what treatment path to pursue, with the physician playing the main role in such decision making.

The "Elbasan General Hospital" Surgery unit had a client satisfaction survey box in the unit but as per staff feedback, this was rarely used. This unit also had anti-corruption posters mounted on the wall, as seen in Figure 56 below:

Figure 56. Elbasan General Hospital Surgery Unit Entrance
(Poster content translation: Corruption is a crime against life. Do NOT take, solicit, give bribes. Please call us at the number below to denounce it. Smoking is not allowed).

Lack of CRPD was noted in both hospitals. Members of staff expressed their dissatisfaction with excessive attention to service user rights and 'staff being watched' for any signs of corruption, as not all of them extort service users. Members of staff also complained of cases of violence against them and lack of protection in both hospitals. Discharge of service users upon treatment completion was reported as a priority in both hospitals in Vlora and Elbasan.

Service users at the "Elbasan Regional Hospital" made reference to lack of intravenous supplies, which are subsequently the responsibility of the service user and their family members to purchase and pay for independently. Even though the "Elbasan General Hospital" had the national list of approved medication posted in the nursing station, lack of intravenous supplies was reported by all service users and their family members. Service users and their family members attributed lack of medication in public hospitals to corruption on the part of surgeons and management team. Assessment of medication administered was not conducted, however, all files in both hospitals, contrary to the psychiatric units, seemed complete with regular updates on medication administered.

Service users and family members spoke highly of the health promotion activities, e.g., diabetes education, on the part of members of staff at the Elbasan Surgery Unit. Surgeon extortion schemes at the Surgery Unit in Vlora appeared to influence service users and their family members' view of the quality of health

promotion activities. Illustrative quotes pertaining to all sub-standards are captured in Appendix V.

In conclusion, the quality of care offered at the “Sadik Dinci” Elbasan Psychiatric Hospital and the “Ali Mihali” Vlora Psychiatric Hospital appeared to be limited. Lack of funding, consequent staff shortages and their lack of clinical training as well as lack of human rights awareness on the part of interviewees from all three groups accounted for this conclusion.

Although quality of care appeared to be influenced by the presence of corruption at the Surgery Inpatient Units in Vlora and Elbasan, active family involvement, in service user recovery was found to be a proxy in decision making and rights protection, unlike in the psychiatric units.

2.4: QUALITYRIGHTS TOOLKIT THEME/STANDARD 3: "THE RIGHT TO EXERCISE LEGAL CAPACITY AND THE RIGHT TO PERSONAL FREEDOM AND THE SECURITY OF PERSON" FINDINGS OF ALL HOSPITALS

Theme/Standard 3 is comprised of the sub-standards captured in Table 19 below:

Table 19: WHO QualityRights Theme/Standard 3 Sub-standards

Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person			
S:3.1 Service users' preferences regarding the place and form of treatment are always a priority	**S:3.2** Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	**S: 3.3** Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	**S: 3.4** Service users have the right to confidentiality and access to their personal health information

Table 20 summarizes all qualitative themes identified for Theme/Standard 3 for all study hospitals.

Table 20: WHO QualityRights Toolkit Theme/Standard 3 Qualitative Data Findings

Themes/Standards	**"Ali Mihali" Vlora Psychiatric Hospital** **N= 25**	**"Sadik Dinci" Elbasan Psychiatric Hospital** **N=25**	**Vlora General Hospital Surgery Inpatient Unit** **N=22**	**Elbasan General Hospital Surgery Inpatient Unit** **N=23**
QualityRights Theme/Standard 3				
Theme	**Lack of mechanisms to support service users' informed decision making, a key feature of treatment model**	**Limited service users' informed decision making, and its role in recovery**	**Limitations to service users decision making freedom**	**Contradictory decision making freedom on part of service users**
Subthemes	Pre-determined access point of health care Psychiatrists as key determiners of course of treatments Limited community infrastructure does not facilitate de-hospitalization of service users Lack of formal procedures and processes to support service users' awareness and understanding of their rights	A top-down approach to access to health care Members of staff (psychiatrists), with limited input from family members determine course of treatments Limited community infrastructure does not facilitate de-hospitalization of service users Lack of formal procedures and processes to support service users' understanding of their rights	Limited formal procedures and processes to support service users' understanding of their rights and the voluntary nature of their admission Service user discharge promoted	Recovery approach as an interactive process between medical staff and family members as informal substitute decision makers, despite service users' provision of informed consent Limited formal procedures and processes to support service users' understanding of their rights and the voluntary nature of their admission

		Stigma on the part of members of staff Limited external support network in decision making		
Theme	**Violation of involuntary procedures despite existing written protocols, in contravention with national and international laws**	**Present yet controversial legal and procedural guidelines regarding voluntary and involuntary admissions**	**Limited application of service users' right to confidentiality with no service user access to their medical file**	**Limited application of service users' right to confidentiality with no service user access to their medical file**
Subthemes	Admissions criteria exist for involuntary admissions Violation of involuntary admission protocols Use of violence in admissions and stigma (Service user's) Lack of support person and/or community representatives supporting service users Confidential files for service users exist but access by members of staff only	Admissions criteria exist for involuntary admissions Ambiguously compliant admissions practices Lack of information provided to service users regarding appeals procedures and legal representation Confidential files for service users exist but access by members of staff only	Mixed attitudes on the part of staff Access to medical files by staff only	Context based confidentiality Access to medical files by members of staff only Stigma on the part of members of staff

Both psychiatric hospitals rated as Achievement Initiated (A/I) in this standard. WHO QualityRatings Toolkit Theme/Standard 3 ratings are captured in Table 21 below:

Table 21. WHO QualityRights Toolkit Theme/Standard 3 Ratings

Hospitals	Ali Mihali" Vlora Psychiatric Inpatient Unit	"Sadik Dinci" Elbasan Psychiatric Inpatient Unit	Vlora Regional Hospital Surgery Inpatient Unit	Elbasan General Hospital Surgery Inpatient Unit
Theme/Standard 3 Ratings	Achieved Initiated (A/I)	Achieved Initiated (A/I)	Achieved Partially (A/P)	Achieved Partially (A/P)

Both psychiatric units rated as: Achievement Initiated (A/I). There is a lack of mechanisms supporting service users' informed decision making. This is determined by the catchment area of the hospital with no input from service users regarding the place where they receive treatment or what type of treatment they receive. The funder/Ministry of Health determines the catchment area for all secondary and tertiary care hospitals in Albania.

In addition, at both hospital, as highlighted in Theme/Standard 2, attending psychiatrists lead and determine the treatment, with some input from psychosocial staff. No written information is provided to service users during the admission process regarding their rights, services available and their role in the recovery process. At both hospitals, service user interviews indicated some input from them is required but only regarding what kind of activities they may enjoy doing, with no room for them to participate in the formulation of the treatment care. This includes a lack of understanding, as well as the absence of the application of the advance directive care model by members of staff and service users.

Service user family member involvement was also reported as limited, even in cases when family members were present, given the lead role psychiatrists play in the treatment process. In all other cases, service users were abandoned by family members. Particularly at the "Sadik Dinci" Elbasan Psychiatric Hospital, input from members of staff and from documentation, indicated that over 150 service users out of 325 service users are abandoned by their families, while the same phenomenon was seen at the "Ali Mihali" Vlora Psychiatric Hospital, although to a lesser extent.

"If a mentally sick family member is not wanted in their home and there is nowhere to send them to in the community, they stay here" (staff member at the "Sadik Dinci" Elbasan Psychiatric Hospital).

Analysis of files at both hospitals showed a lack of procedures regarding the frequency of review of the care plans despite two members of staff at both hospitals indicating that the service user treatment plan should be reviewed regularly on a 6 monthly basis. At both hospitals, members of staff indicated they were aware of limited community resources in their cities and in the neighbouring cities; however, they also reported that it is challenging to deinstitutionalize chronic service users beyond the existing community supported homes which exist in both Vlora and Elbasan. Members of staff at both hospitals indicated that their hospitals provide shelter for long term chronic service users; in Elbasan's case some of them have been there since its opening in 1965.

An illustrative quote is found below:

"Just three supported homes in Vlora, if only we could discharge more patients" (staff member at the "Ali Mihali" Vlora Psychiatric Hospital)

At both hospitals, members of staff and documentation indicated the existence of guidelines with regard to admissions, particularly involuntary admissions, as well as physical restraints based on the "Package of Sub - Legal Acts in accordance with Act 44/2012 of the Mental Health Act". The Ministry of Health of Albania approved forms were available at both hospitals. Staff at both hospitals reported service users are given 48 hours to consent in writing, despite their initial unwillingness when they are admitted in the emergency room. All service users were required to consent in writing for accessing care at such facilities, unless they refused to consent to treatment; in that case, the hospital would be responsible for notifying the district court within 48 hrs of admission. Use of chemical restraining in the emergency rooms was noted. The circumstances under which such service users' consent is obtained at the point of admission in the emergency room remain therefore unknown. The quote below illustrates this finding:

"The old way of practicing, up until a few years ago, did not require any patient consent for admittance. We give them 48 hours to sign the papers, if not, we follow legal procedures and alert the district court who in turn sends its representatives to assess the patients' mental state" (member of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Most service users, particularly at the "Ali Mihali" Vlora Psychiatric Hospital, indicated they were unwillingly receiving care. How their consent was obtained within the first 48 hrs of admission remains unknown, because of the absence of any service user advocates during the consent procurement process, and the service users' lack of knowledge with respect to their rights.

These findings are illustrated below:

"I know I don't want to be here, I don't know anyone to get me out of here. Are you a lawyer – can you get me out of here? I need a lawyer but don't know where to find one" (service user at the "Sadik Dinci" Elbasan Psychiatric Hospital)

“Lots of patients when they arrive don’t want to sign the file, I mean, consent to being here. They usually sign it within two days. I am not sure if patients refusing treatment in such a place is possible, let alone appealing the decision” (staff member at the “Sadik Dinci” Elbasan Psychiatric Hospital)

Members of staff at both hospitals reported services users have no choice but to receive treatment once the court has deemed them as admissible. The hospital members of staff reported use of and compliance with judicial requirements in the case of involuntary admissions, yet, there were service users who reported the need to obtain legal advice regarding their perceived involuntary stay. In reviewing service user files, only one client had not consented at the “Ali Mihali” Vlora Psychiatric Hospital, yet none of the judicial review mechanism as dictated by law was activated in this case. Hence, this service user was held against his will and in violation of judicial review guidelines. This study did not include review of all hospital involuntary admissions as such data was not released by either psychiatric hospital. Neither of the two hospitals released any data on the number of legal guardianship cases.

None of the hospitals have any mechanisms in use to notify and support the service user in accessing legal expertise or assistance in accessing appeal procedures in case of involuntary admissions.

The quotes below illustrate the above-stated findings:

“There are no appeal procedures and no legal representation that patients are informed about. Whatever the court determines, we do” (member of staff at the “Sadik Dinci” Elbasan Psychiatric Hospital)

“My problem is not being able to go, as I am held against my will. I did not sign any papers when I came here, I remember this much” (service user at the “Ali Mihali” Vlora Psychiatric Hospital)

Two family members at the “Sadik Dinci” Elbasan Psychiatric Hospital made reference to use of chemical restraint to ‘calm patients down’ in the emergency room, as was the case of their adult child. Service user input at the “Ali Mihali” hospital indicated that staff were sometimes violent and emotionally intimidating towards service users in the emergency room during the admission process.

Neither of the two hospitals showed involvement of any outside organizations representing service user rights in the case of involuntary admissions because such cases are reported at the district court only. Neither of the two hospitals showed any mechanisms in use which encouraged service user awareness of their rights. No written information is provided to service users and their family members on service user rights.

The quotes below illustrate the findings above:

There are no people in the community who would speak for service user rights” (member of staff at the “Sadik Dinci” Elbasan Psychiatric Hospital)

“Nobody has given me anything about my rights, I must know something though” (service user at the “Sadik Dinci” Elbasan Psychiatric Hospital)

Confidential paper-based charts were used in both hospitals. However they were fragmented as the psychiatric units introduced the new charts in the last 10 years. Chronic service users whose stay at the hospital exceeded 10 years, had original files which did not capture their consent given that consent giving was only formalized in psychiatric institutions in the last 10 years. All charts were kept in chart rooms, as well as in the Chief Nursing office for all chronic service users. No service user or their family members could access their charts. No service user could add any information to their file at either of the psychiatric hospitals.

All study participant interviews showed a lack of any formal procedures and processes to support service users understanding of their rights. This also applied to a complete lack of any external support system, e.g., service user advocates, with an emphasis on application of the substitute decision making model rather than the supported decision making model as indicated by members of staff.

Last, staff interviews revealed stigma regarding mental health as well as the recovery process of people with mental illnesses.

These findings are illustrated via the quotes below:

“This is a psychiatric hospital where people are sick and cannot often be taken seriously for what they say as it could be something they say because they are sick” (member of staff at the “Sadik Dinci” Elbasan Psychiatric Hospital)

In contrast to the psychiatric services, both surgery units rated as Achievement Partially Achieved (A/P). Similar to the psychiatric hospitals, data from both general hospitals showed that attending surgeons lead the decision making process and treatment process, even though service user consent is required. Unlike the psychiatric settings, there is a great deal of family member presence in the care of service users, as shown below:

“I was not alone when the doctor spoke. My family was with me. Doctors don’t complicate things for old people…..” (service user at the “Vlora General Hospital” Surgery unit)

With the exception of a forensic case treated at the “Elbasan General Hospital” Surgery Unit, all other service users were treated only after giving their consent. The quote below illustrates this:

“I signed some papers but don’t remember exactly what they were. Kind of agreeing to anything that could happen to me. This is a different era we live in, saying ‘yes’ to anything that may go wrong….” (service user at the “Vlora Regional Hospital” Surgery Unit)

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Similar to the psychiatric hospitals, there is no information provided by members of staff to service users and their family members on service user human rights. There is some promotion of anti-corruption initiatives and soliciting of service user feedback

about the quality of care at both surgery units. Stigma on the part of members of staff was noted at the “Elbasan Regional Hospital” Surgery unit.

The quotes below illustrate these findings:

“As for patient rights, we don’t provide anything. Curious to know how a patient from Elbasan villages would comprehend the topic of patient rights if written material was to be provided to him or her and what’s written on his file, if he was to access the file…” (member of staff)

“We’re all so sensitized by what is happening with the ‘denounce corruption’ campaign undertaken by the government…” (member of staff)

In addition, there is a confidential file created for each service user which was up-to-date in both units, unlike in the psychiatric hospitals. At both general hospitals, no service user was allowed to access their files.

In conclusion, findings showed that neither of the psychiatric hospitals comply with guidelines to allow service users to practice their legal capacity. This is in contrast to the general hospital surgery units where service users can exercise this right, although family members often serve as a proxy in decision making.

2.5: QUALITYRIGHTS TOOLKIT THEME/STANDARD 4: "FREEDOM FROM TORTURE, CRUEL INHUMANE OR DEGRADING TREATMENT, OR PUNISHMENT, AND FROM EXPLOITATION, VIOLENCE AND ABUSE" QUALITATIVE DATA ANALYSIS OF ALL HOSPITALS

Theme/standard 4 is comprised of the sub-standards captured in the Table 22.

Table 22. WHO QualityRights Theme 4 Sub-standards

Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, or punishment from exploitation, violence and abuse				
S: 4.1	**S: 4.2**	**S: 4.3**	**S: 4.4**	**S: 4.5**
Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect	Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user	No service user is subjected to medical or scientific experimentation without his or her informed consent	Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse

Table 23 summarizes all themes identified for Theme/Standard 4 for all study hospitals.

Table 23. WHO QualityRights Toolkit Theme/Standard 4 Qualitative Data Findings

Themes/Standards	"Ali Mihali" Vlora Psychiatric Hospital N= 25	"Sadik Dinci" Elbasan Psychiatric Hospital N=25	Vlora General Hospital Surgery Inpatient Unit N=22	Elbasan General Hospital Surgery Inpatient Unit N=23
QualityRights Theme/Standard 4				
Theme	**Protection and violation of service user on the part of staff, part of service user experience**	**Contradictory attitude towards service users on the part of staff, with impact on service user recovery**	**Medical professional staff attitude as responsive**	**Medical professional staff attitude as responsive**
Subthemes	Protection of service users on the part of staff Violation of service user on the part of staff and from patient to patient No ECT use and/or medical experimentation	Compassionate as well as verbally disrespectful attitude on the part of staff Presence of policy against service user abuse Lack of information on service user maltreatment Patient to patient violence	The governmental effort on fighting system abuse has medical staff responsive to service users and family members requests	The governmental effort on fighting system abuse has medical staff responsive to service users and family members requests
Theme	**Mixed restraint forms used with service users**	**Mixed restraint forms of service users**	**Limited client feedback soliciting procedures**	**Limited client feedback soliciting procedures**
Subthemes	Use of physical and chemical restraints	Chemical restraints, in the absence of seclusion rooms, as a response to inadequate de-escalation procedures	Pathways to providing feedback Staff training needs Informality and privilege	Pathways to providing feedback Informality and privilege

		Physical restraints, in the absence of seclusion rooms, as a response to inadequate de-escalation procedures Compliant restraint processes with restraint guidelines Stigma (staff's) No ECT use and/or medical experimentation	Trust and mistrust on mechanisms to offer feedback The end result of medical intervention determines if there is feedback initiation	Trust and mistrust on mechanisms to offer feedback The end result of medical intervention determines if there is feedback initiation
Theme	**Staff dissatisfaction, a general sentiment amongst staff**	**Fragmented monitoring mechanisms of service users rights**	**Partial promotion of service users rights and lack of staff rights involve abuse on both sides**	**Partial promotion of service users rights and lack of staff rights involve abuse on both sides**
Subthemes	Monetary reprimands and fear of repercussions Lack of protection in the workplace	Limited presence of an independent body Lack of legal representation/service users advocates Limited access of service users to complaint mechanisms No disclosure of data on service users abuse/neglect and/or any	Perceived and real service user abuse/neglect produces staff abuse Limited staff training on service users rights Lack of posted staff rights	Perceived and real service user abuse/neglect produces staff abuse Limited staff training on service users rights Lack of posted staff rights

		disciplinary action against any person with history of service user abuse/neglect		
Theme	**Limited application of mechanisms promoting service user rights, non-compliant with contemporary standards**			
Subthemes	Formal processes with lack of proactive and ongoing promotion of service rights Limited presence of an independent body Lack of legal representation/service user advocates Limited access of service users to complaint mechanisms No disclosure of data on service users abuse/neglect and/or any disciplinary action against any person with history of service user abuse/neglect			

The “Ali Mihali” Vlora Psychiatric Hospital rated lower than the psychiatric hospital in Elbasan due to service user suggestion of physical violence during the admission process at the “Ali Mihali” Vlora Psychiatric Hospital.

WHO QualityRights Toolkit Theme/Standard 4 ratings are captured in Table 24 below.

Table 24. WHO QualityRights Toolkit Theme/Standard 4 Ratings

Hospitals	Ali Mihali” Vlora Psychiatric Inpatient Unit	“Sadik Dinci” Elbasan Psychiatric Inpatient Unit	Vlora Regional Hospital Surgery Inpatient Unit	Elbasan General Hospital Surgery Inpatient Unit
Theme/Standard 4 Ratings	Achieved Initiated (A/I)	Achieved Partially (A/P)	Achieved Initiated (A/I)	Achieved Partially (A/P)

At both hospitals, all study participant interviews spoke to the presence of physical violence amongst service users which often led to patients being physically hurt, including service user death in the past at the “Sadik Dinci” Elbasan Psychiatric Hospital. A review of documents, as well as members of staff interviews, also spoke to a lack of effective guidelines regarding de-escalation of conflicts amongst service users. However, hospital documents, as well as members of staff interviews, also revealed the presence of policies which address members of staff abuse towards service user. Service user feedback reported members of staff often intervene to end fights amongst service users, which sometimes leads to members of staff getting hurt as a result.

The quote below illustrates the above-stated findings:

“My roommates bother me, sometimes. They start fights, the members of staff protect me sometimes, when they can, they get hit too. I have never been hit by members of staff, when they get upset because of the fights, they yell though, we all, do…” (service user at the “Sadik Dinci” Elbasan Psychiatric Hospital)

In addition, abuse from members of staff towards service users was reported at the “Ali Mihali” Vlora Psychiatric Hospital. This is illustrated below:

“Listen, I stole some money, and my family brought me here. ……I was using some drugs too, and my family did not like it. It’s like they could not wait to get me here. As soon as my family brought me here, members of staff took me in right away. They were very rude and rough with me….they kicked me, they grabbed me by my hair as I did not want to be here…… Who wants to be here, anyway? A person would have to be crazy to want to stay here, isn’t that so?” (service user)

"Not very kind people at the emergency room. They pushed me and kept me here. I don't want to be here, they kept me here…." (service user at the "Sadik Dinci" Elbasan Psychiatric Hospital)

On the other hand, feedback from members of staff speaks to their perceived role in the service user recovery process. This is illustrated in the quote below:

"Our job is a humane job, trying to serve people who are most vulnerable is something that not everyone would do well, I think. It is not just the pay that keeps me here, I feel I help out in this field (member of staff at the "Ali Mihali" Vlora Psychiatric Hospital)

Both hospitals appeared to perform similarly with regard to the use of restraints, both chemical and physical. Members of staff interviews at both hospitals, as well as review of relevant documents, made reference to the presence of formal guidelines on service user restraints. Members of staff interviews referred to the lack of proper physical restraint methods/tools; instead the use of bedsheets was referenced for the purpose of conducting physical restraints. Staff did refer to the process of recording the restraint process in the service user's file and submission of the information to the management team, although there was no mention of oversight from any external service user rights protection bodies. Members of staff also referred to the need for further training on de-escalation of crisis situations.

These findings are illustrated below:

"We have not had a seclusion room for ages. Patients who are very agitated get either chemically or physically restrained at the ER room, and are tied to their bed as per doctor's advice. We don't have to report such cases anywhere. In my view de-escalation strategies don't work when patients are very agitated" (member of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital)

"We have not used the isolation room in 2016, and have been chemical restraint free for 2 years, except for few cases, i.e., in cases of schizophrenia. We try hard not to restrain patients when agitated. However, in the emergency room, in 2016 we had 16 straightjacket cases, and 4 cases in the sub-acute unit. The other way of restraining is via using the belts and bed sheets in bed, for max 15 mins, with the doctor present and with the doctor's directive" (member of staff at the "Ali Mihali" Psychiatric Hospital)

Members of staff indicated the seclusion room which exists at the "Ali Mihali" Vlora Psychiatric Hospital had not been used for a long time; however, during the observation and taking photos of the room, staff were seen to remove a few sets of sheets from that room. Staff interviews at both hospitals indicated sheets are used for physical restraining. In addition, during the observations a service user was seen sleeping in a locked room which was secluded from the other rooms. These seclusion rooms are shown in Figure 57 and 58 respectively below:

Figure 57. “Ali Mihali” Vlora Psychiatric Hospital Seclusion Room in the Acute Unit

Figure 58. “Ali Mihali” Vlora Psychiatric Hospital Secluded Room in the Chronic Service User Unit

Sub-standards 4.3 and 4.4 did not apply to either hospital as neither ECT nor any medical experiments are conducted at these psychiatric hospitals.

At both hospitals, members of staff spoke about the oversight role that the Ombudsman's office plays for psychiatric hospitals. They also made reference to checks and reporting processes on the part of their funder. None of the hospitals released any information on the Ombudsman's reports on annual visits to these hospitals, although this information can be found on the Ombudsman's website. None of the hospitals released any information on abuse of members of staff or of service users. Both service users and members of staff stated there is no presence of any external body to represent service user rights within the hospital, particularly with regard to restraint situations. Members of staff made reference to the media and the public's attempts to denounce abuse in health care through gathering evidence secretly.

These findings are reflected in quotes below:

"The Ombudsman's office visits us" (staff member at "Sadik Dinci" Elbasan Psychiatric Hospital)

"I think it is the trend everywhere these days where staff are video recorded secretly to expose any abuse towards patients…"member of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Figure 59 below refers to contact information of the Ombudsman's Office posted at the "Ali Mihali" Vlora Psychiatric Hospital.

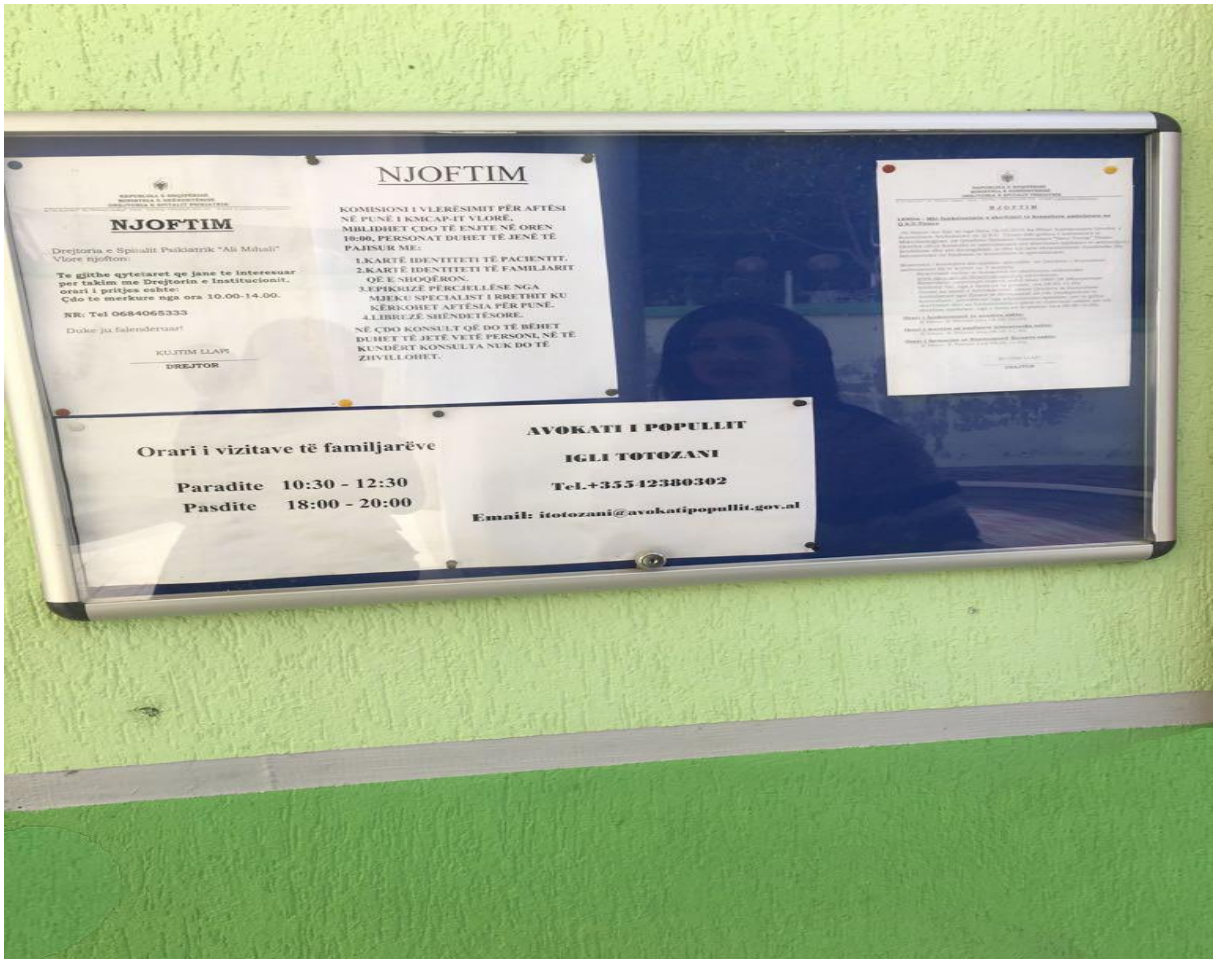

Figure 59. Wall Posters Informing the Public on Access to the Ombudsman's Office and the Hospital Director
(The Ombudsman contact information is found below. The visiting hours for family members are: 10.30am – 12.30pm; 18.00-20.00pm. All citizens who wish to meet with the hospital director, can reach him on the phone number indicated as follows. The Disability Committee meets regularly on the indicated dates)

All three study participant groups indicated there is no formal process of soliciting feedback from service users and family members regarding satisfaction with the care provided, as illustrated below:

"We don't have any mechanisms to inform patients where to complain or file appeals…..At times, family members speak to the director directly" (member of staff at the "Sadik Dinci" Elbasan Psychiatric Hospital)

Members of staff at the "Ali Mihali" Vlora Psychiatric Hospital expressed dissatisfaction with their working conditions and lack of protection in the workplace. This theme arose and was discussed under Standard 3 as well.

The quotes below illustrate this theme:

"….staff have to make sure patients don't destroy hospital furnishings, otherwise they pay out of their pocket which is unfair. Our salaries are low to begin with, let alone covering the cost of furniture damaged. It is the management team's

rule…… I don't want to complain much as I don't want to cause job problems… " (member of staff at the "Ali Mihali" Vlora Psychiatric Hospital)

Similar to the psychiatric hospitals, service user neglect was noted at the general hospital surgery units. Service user input from the Vlora General Hospital about corruption as a barrier to accessing care, was considered an example of neglect under this standard. A lack of intravenous supplies was mentioned at the Elbasan General Hospital. It is beyond the scope of this thesis to determine the factors leading to this shortage (other than to hypothesize that it was related to corruption based on prior research conducted in Albanian hospitals).

No restraint cases seemed to apply to either of these two hospitals, yet members of staff recognized the need to get trained in managing patient expectations and conflict with them and the family members. Neither ECT nor any medical experiments are conducted at these general hospitals.

As with psychiatric hospitals, interviews with service users and family members spoke to a lack of mechanisms for providing feedback, as well as a lack of trust on the part of service users with regard to any such existing mechanisms, i.e., client satisfaction surveys. They made reference to fear of reprisal on the part of the members of staff if dissatisfactory feedback was provided about the quality of care at either hospital. Particularly at the Vlora Regional Hospital, service users and family members spoke about informal mechanisms of securing quality care, i.e., depending on networking connections within the health care system.

In conclusion, data yielded information about the presence of physical abuse on the part of members of staff at the "Ali Mihali" Vlora Psychiatric Hospital, coupled with lack of support from members of staff at the psychiatric hospital in Elbasan as well. Presence of abuse/neglect was manifested in the form of bribe seeking in the surgery unit in Vlora, while lack of essential medication was reported at the surgery unit in Elbasan.

2.6: QUALITYRIGHTS TOOLKIT THEME/STANDARD 5: "THE RIGHT TO LIVE INDEPENDENTLY AND BE INCLUDED IN THE COMMUNITY" QUALITATIVE DATA ANALYSIS OF ALL HOSPITALS

Theme/Standard 5 is comprised of the sub-standards captured in the Table 25 below:

Table 25: WHO QualityRights Toolkit Theme/Standard 5 Sub-standards

Theme/Standard 5: The right to live independently and be included in the community			
S: 5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community	**S: 5.2** Service users can access education and employment opportunities	**S: 5.3** The right of service users to participate in political and public life and to exercise freedom of association is supported	**S: 5.4** Service users are supported in taking part in social, cultural, religious and leisure activities

Table 26 summarizes all themes identified for Theme/Standard 5 for all study hospitals.

Table 26. Theme/Standard 5 Qualitative Data Findings

Themes/Standards	"Ali Mihali" Vlora Psychiatric Hospital N= 25	"Sadik Dinci" Elbasan Psychiatric Hospital N=25	Vlora General Hospital Surgery Unit N=22	Elbasan General Hospital Surgery Unit N=23
QualityRights Theme/Standard 5				
Theme	**Serious lack of community infrastructure to support de-institutionalization**	**Serious lack of community infrastructure to support de-institutionalization**	N/A	N/A
Subthemes	Lack of community resources to respond to treatment needs in the case of deinstitutionalized patients	Lack of housing for people with mental disorders Lack of community resources to respond to treatment needs in case of deinstitutionalized patients		
Theme	**Lack of resources, a serious limiting factor**	**Lack of resources, a serious limiting factor**		
Subthemes	Lack of funding	Lack of staffing resources Lack of funding		
Theme	**Infringement of enjoyment of life; a life with significant limitations**	**Stigma, and its impact**		
Subthemes	Limited quality time and infringed rights	Stigma on the part of staff Stigma on the part of family members		
Theme		**Infringed enjoyment of life**		
Subthemes		Limited availability of leisure activities		

Both psychiatric hospitals were rated as Achievement Initiated (A/I). They have the same rating because similar themes were identified in the interviews in each psychiatric hospital and similar observations were made in each.

WHO QualityRights Toolkit Theme/Standard 5 ratings are captured in Table 27 below.

Table 27. WHO QualityRights Toolkit Theme/Standard 5 Ratings

Hospitals	Ali Mihali" Vlora Psychiatric Inpatient Unit	"Sadik Dinci" Elbasan Psychiatric Inpatient Unit	Vlora Regional Hospital Surgery Inpatient Unit	Elbasan General Hospital Surgery Inpatient Unit
Theme/Standard 5 Ratings	Achieved Initiated (A/I)	Achieved Initiated (A/I)	N/A	N/A

Both psychiatric units' staff made reference to the initiation of the community based housing in Vlora city and Elbasan city. Despite these developments, key themes showed there was a serious lack of community infrastructure to support de-institutionalization. Staff interviews indicated staff knowledge about the services that are available, including the establishment of community mental health centres in each city as well as three supported accommodation homes in Vlora and two in Elbasan, which were under the jurisdiction of the two hospitals. These two hospitals still offer inpatient accommodation to large numbers of chronic service users, in addition to people with disability whose stay at these hospitals has been dictated by lack of housing and community infrastructure for them.

These findings are illustrated via quote below:

"I have not been anywhere. I want to go out more often. I want to touch Vlora's sea water again….maybe one day I will do so (service user)

Staffing members spoke to limited employment opportunities for service users who are discharged, unless they help out within the hospitals and get paid the minimum wage. A member of staff also referred to stigma; the theme of societal stigma and its impact on service user employment is captured below:

"If only we could accommodate patients in the community, some would have to live in locked places though as a few of them are not well to be let free. You must have heard of the case of that man with past psychiatric history who beheaded his teenage nephew. He was let free without any monitoring on the part of medical staff in the community" (staff member at the "Sadik Dinci" Elbasan Psychiatric Hospital)

“We want to have as many patients who get discharged to be able to get some trades training and then work. It’s challenging though, quite a bit as even places which may have some work, they won’t hire our ex patients due to stigma. That’s why we have a long way to go as a society” (staff member at the “Ali Mihali” Psychiatric Hospital)

Data showed little to no efforts were made to support service users to participate in political and public life. This is captured in the following quotes:

“No one votes here. We try to keep politics out of here. Some long-term patients ended up here because of being political dissidents, it cost their life….” (staff member at “Sadik Dinci” Elbasan Psychiatric Hospital)

At both psychiatric hospitals, psycho-social members of staff make efforts to support service users’ access leisure activities. However, lack of resources was a theme found in both psychiatric hospitals, despite the increase in the number of staff over the past few years.

This finding is captured in the quote below:

“Almost everyone wants to go out on mini buses, have some coffee in town, go sightseeing, it’s not possible, a) some patients are very sick and cannot get out of here, b) never enough staff to do frequent outings. A psychiatric hospital is not a good place to be in….unless you need to…” (staff member the “Sadik Dinci” Elbasan Psychiatric Hospital)

Figures 60 and 61 shows hospital premises geared to offer recreational and rehabilitation activities in Elbasan and Vlora respectively.

Figure 60. The “Sadik Dinci” Elbasan Psychiatric Hospital Occupational Centre

Figure 61. The “Ali Mihali” Vlora Psychiatric Hospital Gym

In conclusion, while theme 5 does not apply to surgery units due to the nature of care offered in such units, findings from the psychiatric hospitals showed that both hospitals have made efforts to incorporate recovery oriented services that aim at discharging service users contingent upon availability of community resources. Both hospitals appeared to face significant challenges regarding lack of community infrastructure which does not support the de-institutionalization process of these service users. In addition, societal stigma, stigma on the part of family members and staff members at psychiatric hospitals was reported.

SECTION 2: SUMMARY

This chapter provided a comparative summary of data collected across all four study sites based on the WHO QualityRights Toolkit themes.

The comparative summary of data collected at all study hospitals was done for the purpose of highlighting any quality of care differences and subsequently any differences in protection of human rights between psychiatric and general hospital surgery units. It illustrated the findings with photos from hospital premises and illustrative statements from all three groups of stakeholders.

While these findings will be discussed in detail in the next chapter, data overall showed that the psychiatric settings rated lower than the surgery inpatient units. Key themes/factors which accounted for these differences were: lack of funding, presence of stigma on the part of all three study groups, as well as a lack of awareness of service user human rights on the part of all three study groups, primarily members of staff.

Last, corruption on the part of medical personnel was reported in the surgery units.

CHAPTER VI: FINDINGS DISCUSSION

SECTION 1: INTRODUCTION

This chapter discusses key findings as they pertain to the objectives and research questions of this study. Reflections on the most recent Albanian health care system developments are offered as they are an attempt to shed light on the quality of the connections between state of care and human rights. Recommendations are made regarding next steps, based on study findings.

SECTION 2: FINDINGS DISCUSSION

This study attempted to address two key questions as well as the following sub-questions:

The Research Key Questions are:

- Do the Albanian inpatient psychiatric units at the 'Ali Mihali' Vlora Psychiatric Hospital and the 'Sadik Dinci' Elbasan Psychiatric Hospital meet Human Rights standards?

- To what extent does the WHO QualityRights Toolkit accurately measure human rights protection within the Albanian perspective?

The Research Secondary Questions are:

1. Are negative rights met in the psychiatric inpatient study settings?
2. To what extent can positive rights, within the mental health context, be met in a developing country such as Albania?
3. How does poor quality of care become a human rights issue in psychiatric inpatient units?
4. Are there any differences in human rights protection between psychiatric inpatient services and surgery inpatient units? If so, what factors/themes may speak to any reported differences?
5. Does the WHO QualityRights Toolkit accurately measure human rights protection within the Albanian perspective?

While there are a number of themes and sub-themes emerging in this study, the data collected via triangulation of different methods points at three main qualitative themes across all hospitals:

1) Lack of funding and resources as key contributors to the current state of care and inpatient unit conditions at the study sites, much more pronounced at the psychiatric hospitals;

2) Prevailing corruption in health care, particularly pronounced at the Surgery Inpatient Units;

3) The cultural legacy of Albania's past regime: stigma regarding mental disorders and lack of awareness of human rights at large, much more pronounced in the psychiatric inpatient settings.

This chapter will examine QualityRightsToolkit Themes/Standard 1-5 findings in detail as a way of answering the questions raised by this study. Question 5 will be addressed in Chapter VII.

2.1: WHAT STORY DID THE KEY THEMES TELL?

The following are the themes identified via the qualitative data analysis:

2.1.1: LACK OF FUNDING AND RESOURCES

The impact of the inadequate funding and consequent lack of resources, both in terms of facilities and staffing, has resulted overall in a poor standard of care. This impacts on service users' quality of life and so on their human rights as reflected in Standard 1, 2 and 5. These findings address Question # 2; they show the limited extent to which positive rights are met in the study settings, with a much more pronounced impact in the psychiatric inpatient units. Lack of funding and its impact on the service delivered at the study sites is better understood in light of data discussed earlier in this thesis. Albania ranks amongst one of the poorest countries in the Balkans (WHO, 2014b) which impacts and informs the variety of, and quality of care provided in publicly funded health care, based on the GDP share on health care (Vian, 2011; Tomini et al., 2015). Despite funding increases in mental health services post 2000, inadequate funding continues to be a challenge for psychiatric hospitals (Demi and Voko, 2014).

With regard to QualityRights Toolkit Theme/Standard 1: "The right to an adequate standard of living" findings showed that with the exception of the newly built acute psychiatric units in Vlora, which represented 23% of the hospital bed occupancy, the rest of the premises appeared to be impoverished and offer inhumane living conditions. These settings are crowded and are characterized by the poor physical state of all indoor settings ranging from bedrooms, to showers, washrooms and kitchen areas as well as lack of privacy amongst service users.

Lack of funding in publicly funded health care in Albania has been prevalent since 1991 (Vian, 2011), and significantly more pronounced in psychiatric settings, which accounts for the impoverished state of psychiatric settings. As of 2010, only 4.1% of government health care expenditures were intended for mental health services, 60% being directed to the community-based services, although the psychiatric hospitals in Elbasan and Vlora are the largest mental health settings in Albania (Demi and Voko, 2014). This marked lack of funding in psychiatric settings versus the general health settings appears to resemble the 'Cinderella services' phenomenon found in countries such as the UK (Orr, 2013). Mental health care is underfunded globally as well (Knapp and McDaid, 2007). Reported stigma on the part of policy makers is often found as the reason for poor funding of the mental health sector (Parker, 2007) and this may explain the limited amount of funding mental health

services receive in Albania. The extent to which this stigma impacts funding and efficient utilization of funds in the psychiatric settings in Albania remains to be explored.

The amount of capital investments in the psychiatric hospitals compared with investments available to tertiary specialty care hospital settings, as is the case of the surgery units, remains unknown. However, study findings showed that in 2016-2017, the physical state of the surgery unit buildings was of better quality than that of the two psychiatric units. The Elbasan General Hospital Surgery Unit replaced its old surgery unit building although there are still functional limitations, e.g. partial fire safety systems in place, lack of modernization of service user beds, etc. As study findings showed, the Vlora General Hospital Surgery Unit had undergone some renovations and it was similarly functional like the Elbasan General Hospital Surgery Unit. Despite renovations undertaken at the "Sadik Dinci" Elbasan Psychiatric Hospital, the state of this hospital appeared to be less suited to service user needs than the surgery units; significant overcrowding and safety issues for both service users and staff were noted. The newly built acute service user buildings in Vlora offered much more comfort to service users, yet only a small number of service users are accommodated in the new buildings (34 out of a total of 113).

Pronounced lack of funding in psychiatric settings appeared to be an influential factor on ratings of QualityRights Toolkit Theme/Standard 2. Therefore it speaks to the limited extent positive rights are met in psychiatric units. While there were no admission barriers at either psychiatric hospital, shortage of clinical staffing to meet service user volumes and needs was noted in the psychiatric units. Albania has the lowest number of mental health professionals (psychiatrists, nurses, psychologists, etc.) per 100,000 inhabitants in Europe (WHO, 2008a; Como, 2015).

In addition, limited utilization of service-user driven recovery plans was found in both psychiatric settings and staff partly attributed this to staff shortages and overload. Lack of adequate psychiatric inpatient staffing to support service users to enjoy Theme/Standard 5 rights in psychiatric units was reported in both hospitals. This appeared to impact the quality of care indicating the limited extent to which positive rights are met in Albania's psychiatric units, as addressed by Question # 2. The presence of a national list of approved medication was reported; appropriate use of medication was, however, not evaluated in this study. This could serve as fertile research grounds for future studies in addition to assessing the interplay amongst varying factors impacting the state of this rating on Theme/Standard 2 findings.

Lack of funding appears to be a key factor influencing the current limited state of deinstitutionalization efforts made on the part of both hospitals and the Ministry of Health of Albania. Albania's limited efforts to deinstitutionalize a few of its chronic service users is characterized by a poor community based services infrastructure and cost-containment needs (Mueller, 2013). The number of current supported homes (11 homes for the whole country) does not adequately respond to the deinstitutionalization needs of the many chronic users still hospitalized (Demi and Voko, 2014). This is in contrast to the surgery units, where the study data showed service users are discharged shortly after completing intervention at such units, consistent with service users and their family member expectations. Lack of funding to support the deinstitutionalization process is seen as a contributing factor to the current lengthy hospital stay of current chronic service users. This study showed that the longest stay

at the “Sadik Dinci” Elbasan Psychiatric Hospital is since its opening in 1965 and at the “Ali Mihali” Vlora Psychiatric Hospital it is since 1981. This is significantly longer than 180 days, which is considered an extensive length of stay for service users with serious mental illness, e.g., schizophrenia (Jacobs et al., 2015).The length of stay over 1 year was 77% of service users at the “Ali Mihali” Vlora Psychiatric Hospital and 80% of all service users at the “Sadik Dinci” Elbasan Psychiatric Hospital. Deprivation of liberty in overcrowded psychiatric institutions may constitute abuse (UN, 1999; Lavagnoli, 2011) which reflects the unmet negative human rights in psychiatric units as addressed by Question # 1. Study results also showed these psychiatric hospitals offer shelter to service users with intellectual disabilities although this clientele group require different service care models (Oakes, 2015). In addition, creation of community-based housing for people with mental disorders, has been met with stigma from the residents where such houses are placed (Lamcja, 2016). Stigma could impact service users’ wellbeing due to being a significant predictor of poor mental health (Corrigan and Watson, 2002; Corrigan et al., 2003).

Lack of funding, staff shortage and resources, as the study findings showed, are also linked with a lack of expertise and training in the mental health field on the part of some members of staff. This includes training about service users human rights. These findings are consistent with similar global findings in this area (Drew et al., 2011). Study findings showed that in both psychiatric units, despite staff training conducted thus far, staff lacked sound knowledge of good practices and standardized care in mental health, e.g., group treatment protocols and recovery based interventions (Hajdini, 2009; Demi and Voko, 2014). This limits the extent to which positive rights can be met in a country such as Albania as addressed by Question # 2.

There is a similar issue with a lack of expertise at the Vlora Regional Hospital, where there is a lack of specialists in the field of neurosurgery, cardio-surgery, and occupational diseases which creates service access issues (Together for Life, 2017). Lack of endorsement of patient rights and relevant legislation was also noted. Low salaries in the health care field may discourage the medical personnel from providing quality care across mental health and general health services in Albania (Vian, 2011).

Lack of quality of care in psychiatric settings is seen as a factor that impacts service users’ human rights, e.g., right to mental health (WHO 2008b; Funk et al., 2010; Drew et al., 2011). Consequently, it limits service users’ ability to pursue full enjoyment of their other human rights, e.g., second generation rights. This interdependency between quality of care and human rights in mental health (Dudley, Silove and Gale, 2012), appears to influence the limited extent to which positive rights/2nd generation rights are met in Albania’s impoverished psychiatric inpatient units. Funding availability appears to be a key influential factor on quality of care delivered (WHO, 2008b), which is influenced by the socio-economic development of a country (WHO, 2008b), amongst other factors earlier noted, as addressed by Question # 2 and # 4.

In addition, lack of advance directives was found in this study which is prevalent in psychiatric units across the world (Drew et al., 2011). This included lack of any CRPD knowledge in these psychiatric hospitals.

2.1.2: PREVAILING CORRUPTION IN HEALTH CARE

The study findings spoke to the efforts made at the time of this study on the part of the Albanian government to fight the corruption in the health care system. Despite such efforts, corruption appeared particularly prevalent in the surgery units. Albania ranks 91 out of 180 countries regarding prevalence of corruption (Transparency International, 2016). Within the Albanian health care context, corruption is seen in relation to the management of the hospitals which have been accused of corrupt practices. The crisis in trust with medical personnel is a well-known phenomenon in Albania due to a number of factors which include the desperate and exhaustive efforts of patients trying to gain access to care in exchange for bribing the medical personnel (Vian, 2011).

Controversial procurement processes which often lead to compromised quality of care, has been a common phenomenon in publicly funded settings in Albania post 1991 and are usually a manifestation of corruption (Vian, 2011). The reason for the lack of compliance with international standards in the new buildings in the acute units at the “Ali Mihali” Vlora Psychiatric Hospital and the Surgery Unit at the Elbasan General Hospital remain unknown; it may suggest controversial procurement processes. The study findings showed the acute units lacked a fully built in safety system (sprinkler system), and suffered from poor quality of internal building materials, e.g., wall plasters, while the surgery units lacked fully equipped service user bed head panel stations. This lack meant that family members had to call for medical attention when needed. The state of residential units does impact the extent to which the service user rights are met under Theme/Standard 1.

Corruption negatively impacted access to treatment and to medication on the part of service users in the Surgery Inpatient Units in Vlora and Elbasan, respectively. A lack of medication at the Elbasan Surgery Unit was seen as the main form of corruption, given the vital role that intravenous medication plays, consistent with findings from Lika (2013). At Vlora Surgery Unit, informal payment of surgeons, otherwise known as the phenomenon of “bakshish” (bribe/tip) was seen as the main issue, due to concerns about accessing care. While service users did not reveal the monetary amount requested by admitting surgeons, they did report that ‘bakshish’ is a real corrupting barrier to health care, hence limiting the extent to which service user positive rights, e.g., the right to health, are met. It appears that despite the Albanian government anti-corruption/bribery initiatives, which place the onus of responsibility on the family members and service users to denounce any form of corruption, corruption was in fact still prevalent in the Surgery Units when this study was conducted. The study brought to light two examples of this: a conflict of interest exists for treating physicians who extort service users (Veerschor, 2010); patients often purchase medication from the privately owned pharmacies within the hospital campus due to barriers in accessing hospital medication (Vian, 2011).

Albania, despite being a poor country, has the highest rate of informal payments in the health care sector in the Balkans (Tomini et al., 2015). Up to 88% of the population has made informal payments (Bonilla – Chacin, 2003; Hotchkiss et al., 2004). Albanians view health as an entity that is worth investing in even though this represents a heavy burden on household income. In 2015, the former Executive Director of the “Sadik Dinci” Elbasan Hospital, had his employment terminated and was

legally prosecuted due to the medications procurement process scandal (Gazeta Tema, 2015). In 2014, the former Executive Director of the “Ali Mihali” Vlora Psychiatric Hospital also had his employment terminated due to similar reasons, as well as a lack of investment in the hospital building infrastructure (Skuqi, 2014; Fax.al, 2015). Despite attempts by Albania’s Ministry of Health to tackle corruption (Ministry of Health of Albania, 2015), it still appeared to be prevalent in Albanian hospitals. Both media and NGOs are seen as important in promoting patient public interest (Theobald et al., 2002). The Albanian media, e.g., “Fiks Fare” program, is aimed at investigating cases of corruption; NGOs, like the “Together for Life” (2017) play a role in promoting citizen empowerment. A few study participants initially questioned the authenticity of the study; they wondered if the interviewers were related to “Fiks Fare” program.

Even though Albanians pay informally for access to care, this study showed that fear of the ‘revolving door’ phenomenon affects their intentions to denounce corruption. Both fear of reprisal while in care, as well as due to the idea of needing medical services in the future (’revolving door’), deterred users from reporting corruption, consistent with literature findings (Rose-Ackerman, 1999).

In 2009, Albania, approved the Patient Bill of Rights under the lead of the National Centre for Quality Assurance, Safety and Accreditation of Health Institutions (Ministria e Shendetesise e Shqiperise, 2009). Since then, there has been some progress, for example, the establishment of the National Agency of Quality Assurance and Accreditation. However, not a single Albanian hospital, including psychiatric hospitals, underwent accreditation until 2016-2017. A strong governance structure, is amongst other factors, of paramount importance in fighting corruption in the Albanian health care system (Vian, 2011), given the impact corruption has on the infrastructure of developing countries (Kenny, 2009).

Poverty, as a long standing legacy of Albania’s past political system, has been an underlining factor of corruption in Albania. Theft of hospital equipment by family members was seen in study findings at the Vlora Regional Hospital. This was a phenomenon predominantly prevalent post 1991 in Albania. It could be considered an indication of the prevalence of poverty in countries like Albania whose current economic growth is the lowest in Europe with an average monthly wage of 330 euros (INSTAT, 2016). Remnants of the past system could be an explanation for Albania’s current realities as they are a reflection of the extreme poverty which prevailed for many years in Albania during the dictatorship (Muzeu i Memories, 2014).

2.1.3: THE CULTURAL LEGACY OF ALBANIA'S PAST REGIME

Mental health stigma was seen across both psychiatric hospitals. Study findings showed internalized stigma on the part of a number of service users, as well as stigma on the part of members of staff, at both psychiatric hospitals. This is consistent with global findings (Drew et al, 2011), and specifically prevalent in former dictatorship countries (Tomov et al., 2007). In Albania, stigma about mental health and disabilities, including amongst health care personnel, as well as very limited exposure to Western mental health, were characteristics of the Albanian mental health services during the 45 years of dictatorship (Weinstein et al., 2000). Findings showed a lack of family involvement/abandonment. This is possibly due to the long standing hospitalization history of these service users, family member migration, and/or stigma on their part. Data from the surgery units showed that family involvement is key to service user recovery and promotion of quality of care. There are consistent findings that public stigma and self-stigma affect quality of life, and mental health patient treatment outcomes (Corrigan and Watson, 2002).

Institutionalization perpetuates prevalent stigma related to mental disorders, as seen at both psychiatric hospitals in Vlora and Elbasan, and subsequently further discriminates against people with mental disorders, which represents a human right issue for its direct impact on their health and quality of life (Jacob, 2001; Ritsher and Phelan, 2004). This, coupled with a marked lack of resources and subsequently poor quality of care, more pronounced in low income countries (Drew et al., 2011), as is Albania's case, further negatively impacts their health and recovery and subsequently their quality of life (WHO, 2012), and the ability to pursue and enjoy their human rights, for example the right to live independently (Gable and Gostin, 2009; Funk et al., 2010; Angelova-Mladenova, 2017).

Limited knowledge of human rights and violation of rights was seen in both psychiatric hospitals, as well as in the surgery units. Findings indicated limited knowledge and promotion of human rights on the part of staff members and even more so on the part of service users and their family members, with a direct impact on the limitations of service user freedoms as addressed by Question # 1. Reporting protocols for involuntary admissions were found to be violated at the "Ali Mihali" Vlora Psychiatric Hospital. It is unclear how the process for obtaining informed consent from service users within 48hrs of admission in inpatient units happens. Lack of mechanisms to support service users and their family members exercise their legal capacity as well as service user rights to access their personal health information were reported in both hospitals. This is another indication of violation of their negative rights as they pertain to Question # 1. In order to manage physical unrest on the part of the service users according to the written protocols of the Ministry of Health of Albania (2013), chemical restraining as well as physical restraining in the form of 'tied in bed', was reported at both psychiatric hospitals.

Overall violations of human rights impact people's health and subsequently their quality of life (Drew et al., 2011). Examples of such negative rights violations include presence of abuse and congregation in large institutions (captured in Themes 3 and 4) (UN, 2016), lack of exercising legal capacity and other rights, uninformed consent to treatments/involuntary treatments (WHO, 2012b). The CRPD suggests that physical

restraining should be used only as the last resort and is done only after ensuring that safeguards to protect service user safety and rights are in place (UN, 2006), including access to an independent periodic review for people involuntarily treated or admitted to services (WHO, 2012b). Chemical restraining use was reported during the admission process, including in the case of involuntary admitted services users. Deprivation of one's liberties in this way constitutes human maltreatment (UN, 1999). Overall, violations of service users negative human rights such as: presence of abuse and congregation in large institutions (UN, 1999; Savagnoli, 2011); lack of exercising legal capacity and other rights, uninformed consent treatments/involuntary treatments (WHO, 2012b), impact people's health and subsequently their enjoyment of other human rights and overall quality of life (Drew et al., 2011).

In addition, study findings showed verbal and physical abuse on the part of members of staff towards service users, which constitutes violation of human rights as they pertain to Question # 1 and is consistent with global findings regarding abuse of people with mental disorders in psychiatric settings (Saraceno and Saxena, 2005; Funk et al., 2010; Dudley, Silove and Gale, 2012) and their negative and positive human rights violation as addressed by Questions # 1 and # 4.

On the other hand, the findings from this study contradict the findings of the Council of Europe visiting committee at the "Sadik Dinci" Elbasan Psychiatric Hospital in 2014 (Council of Europe, 2016). Service user freedom of movement appeared to be far more controlled along with controlled routines for sleep hours, etc. than what the Council of Europe visiting committee observed in 2014. No such limitations were seen at surgery units. This control of service users is a reflection of the fact that human rights protection in Central and Eastern Europe is unsatisfactory (Saraceno and Saxena, 2005). As a service user stated: "getting into the Vlora Psychiatric Hospital is not a problem, getting out is", which is an example of negative rights not being met in these psychiatric settings as addressed by Question # 1.

Study findings showed that there is this wide discrepancy between policies and practices, especially in the psychiatric settings in Albania. Such findings were consistent with findings from the study conducted using the QualityRights Toolkit in Greece (Nomidou, 2012). The passing of legislative Acts in Albania has not translated into practices which protect and promote service user rights particularly in the two psychiatric hospitals, i.e., Albania has ratified the CRPD, yet shows limited compliance with Toolkit QualityRights standards as this study has established. Study findings spoke to a lack of awareness of the CRPD amongst members of staff as well as other study participant groups. It also highlighted the lack of overseeing mechanisms of policy implementation, other than the limited presence of the Ombudsman's office once a year. In addition, there was an option to speak to senior management staff and the contact information of Albania's Ombudsman's office was posted; however, some study participants reported being unwilling to use these channels because of fear of reprisal.

Such phenomena are a manifestation of the overall lack of culture of human rights in Albania by and large, and in particular of the legacy of Albania's past Communist system of discrimination towards the human rights of people with mental disorders. Furthermore, "window dressing" solutions (Hafner-Burton and Tsutsui, 2005) regarding ratification of international conventions, such as the CRPD, have been

used in an attempt to gain candidacy status for EU membership, including opening EU membership accession negotiations (EU, 2018).

Members of staff from both psychiatric units reported the fear of reprisal and job loss in offering their feedback regarding the state of care and human rights protection in psychiatric hospitals. This mounting pressure has implications for the psychiatric institutions as Albania is on the path towards opening accession negotiations in June 2019. Protection of fundamental rights at large is a key area Albania is expected to continue building on (EU, 2018).

Subsequently, production of relevant legislation which is not aligned with the CRPD, as well as non-compliance with the Albanian Mental Health Act (Ministria e Shendetesise, 2013) may be reported themes/factors which may account for the differences in human rights protection and quality of care ratings in psychiatric settings versus surgery units as addressed by Question # 4. A pronounced lack of family involvement in the lives of service users in psychiatric study settings could be another factor accounting for human rights protection and quality of care differences between the study settings. Family involvement has been seen as an important proxy in decision making in health care in Albania (Vyshka and Kruja, 2011).

Reported violations of the rights of people with mental disorders in psychiatric units could also be a reflection of Albanians' current understanding and respect for human rights in general. Albanians suffered over 500 years of occupancy under the Ottoman regime, the country with the longest stay under this empire in Europe. It subsequently experienced invasions during World War I and World War II, followed by the 45 year dictatorship under the Hoxha regime. It is therefore only fair to assume that post 1991, Albanians after many years of occupancy and dictatorship, have wrestled with understanding and applying human rights as a nation. This is furthermore complicated by the fact that surviving 45 years of dictatorship and extreme poverty (Hardison, 1996; Schmidt, 1998), may have generated mental health trauma (Amy, 2017).

On the other hand, a general lack of knowledge and promotion of staff member rights was reported. In Albania, violence against medical staff members in general has been prevalent post 1991, and it is also prevalent in psychiatric units (Demi and Voko, 2014). This follows a long standing history of lived and perceived barriers to accessing quality of care in the public health system post 1990s and ever decreasing credibility for this group of professionals which promoted out-of pocket/bribery payments (Vian, 2011). The abuse varies between verbal, physical, and emotional and leads to a compromised relationship between patients and service providers (Brahimaj, 2017). The increase in violence against staffing members is consistent with the increase of injured staff globally, by 22% in 2015 (Kezman, 2016 cited in Brahimaj, 2017). Subsequently, a change in national legislation protecting medical personnel has been warranted in Albania (Brahimaj, 2017). The question is how the state will indeed address the protection of the service user rights while addressing physician compensation issues in a country such as Albania. This matter arises in light of compensation challenges being attributed as the main cause of bribery of medical staff in Albania (Vian, 2011).

Separate from the out-of-pocket/bribery related violence towards members of staff, the staff in both study psychiatric units spoke about personal safety challenges

they have experienced due to the staff safety risks psychiatric units present with. This is consistent with similar findings globally in psychiatric units across the world (Anderson and West, 2011). Globally speaking, the human rights of providers of health care are consolidated in a number of international treaties as listed in Table 28; Albania could benefit from comprehensive compliance with these:

Table 28. Summary of Rights of Staff

Right	Treaty Provisions
Right to decent conditions	ICESCR, ACHPR, ESC (European Social Charter)
Right to freedom of association	ICCPR, ACHPR, ECHR (European Convention on the Protection of Human Rights and Fundamental Freedoms)
Right to due process	ICCPR, ACHPR, FCNM, ECHR

(Cohen and Ezer, 2013).

Both study hospitals in Elbasan and Vlora treat people with intellectual disabilities. The current modest deinstitutionalization which has taken place may be seen as the answer to their unnecessary hospitalization, but there is a risk of trans-institutionalization of residents if staff in the supported living homes are not supported with ongoing training, support and supervision (Oakes, 2015). In addition, adequate infrastructure is warranted. Staff members in supported living homes need to be supported with ongoing training, support and supervision (Oakes, 2015). The challenges facing Albania's inpatient psychiatric services appear to be, to an extent, a reflection of the challenges facing Albania's health care sector as a whole. However, the psychiatric study settings face particular challenges: a pronounced lack of funding, varying forms of abuse of services users as well as violation of their legal capacities. There is evidence that high level officials in Albania are politicized and have conflicts of interests which affect their decision (Vian et al., 2006).

The study findings show that 25 years after the collapse of Communism, there are a number of different factors contributing to the infringement of negative and positive rights in the psychiatric study units: overcrowding of residential units, lack of funding and resources, lack of effective governance, entrenched practices dating from the Communist era, staff resistance to change, corruption and lack of political will, as well as a lack of awareness of service user human rights on the part of members of staff, service users and family members.

To conclude, even if Albania's economic challenges are resolved in the future, so that availability of resources no longer presents a major barrier in mental health services, Albania still has to overcome the cultural legacy of Communism and embrace human rights at large, and most specifically in the context of people with mental illnesses. Therefore, human rights protection in health care, can be seen as an inseparable process of societal development rather than just a dichotomous division between positive and negative rights and consequently their protection processes.

SECTION 3: STUDY RECOMMENDATIONS AND IMPLICATIONS

Albania's commitment to promotion and protection of human rights of people with disabilities, via ratification of the CRPD in 2013 (UN, 2016), consolidated its good will to continuing to build on the institutional and legislative changes already embarked upon with its 1996 Mental Health Act. Nevertheless, the results of this study point at a range of recommendations and policy implications at three governance levels: micro (institutional), mezzo (community-based) and macro (policy making).

1) Micro (institutional) level recommendations and relevant implications:

The aim of the Albanian Mental Health Act has been the deinstitutionalization process in Albania, amongst other priorities (Ministria e Shendetesise, 2013. There is a need, however, to ensure that such efforts do not lead to the 'revolving door' phenomenon often seen in many countries since it has a negative impact on client recovery (Hopper, Jost and Hay, 1997; Luhrmann, 2007).

A significant implication is that staff training, support and supervision is warranted to decrease the chances of this happening (Demi and Voko, 2014; Oakes, 2015). This could be achieved via fostering of professional networking on the part of members of staff with other mental health institutions, as has been the case of the partnership of the "Ali Mihali" Vlora Psychiatric Hospital with a Mental Health Team in Puglia, Italy. Training evaluation strategies would be warranted to assess change in staff members' behaviours pre and post training, which could be embedded in the operational plan of each facility.

A second implication speaks to the importance of seeing service user engagement as crucial in service user recovery (Funk, Drew and Saraceno, 2007). Various methods have been tried to encourage this, for example, the Family Councils or Advocacy Groups, e.g., the Circles Network and its Advocacy Groups in the UK (Circles Network, 1994); in Sweden, the Personal Ombudsman (Choices, 2014); as well as the peer support programs in Canada (Canadian Mental Health Association, 2015). Awareness of service users' rights positively affects mental health service users' engagement with their treatment (Beran and Zavazalova, 2000), the latter in turn is found to lead to improved therapeutic outcomes. Collaboration and inclusion of mental health patients and their family members are characteristics of recovery oriented services (Sowers and Marin, 2014). Service user engagement could be similarly promoted in Albania: people with lived experienced and their family members can be supported to form and/or join advocacy groups.

A third implication refers to the extent to which service user could be engaged in their treatment plan, as well as the degree of awareness of their rights, which impacts the quality of care they receive and subsequently service user recovery (Funk, Drew and Saraceno, 2007). Service user education facilitated by staff members is warranted. Across the world, there is importance placed on the awareness of human rights of service users on the part of the health care personnel as well.

Fourthly, supporting members of staff to enhance their awareness of service users' human rights, with an emphasis on promoting the supported decision making model and alternatives to restraint, would address the current gap identified by this study. Globally, lack of knowledge of patient human rights could lead to violations (Hojjatoleslami and Ghodsi, 2010) and could be a predictor of negative attitudes amongst mental health care personnel. Consistent findings speak to a positive correlation between protection of human rights and provision of higher quality of health care to clients (Brody, 1992; Fletcher, 1992; WHO, 2000; Ozdemir et al., 2006) that challenges stigma, promotes patient civil liberties and supports client sustainable recovery (Killaspy et al., 2009*).*

Fifthly, both psychiatric hospitals in Albania should clearly review their restraints methods as well as account for their use particularly during the admission process in the emergency room. Consistent findings indicate the Human Rights approach has proven more effective than the alternative approaches of left or right dictatorships that failed in Latin America, Central and Eastern Europe, Africa and Asia (Donnelly, 2011); it should therefore be embraced in Albania's psychiatric hospitals as well, despite the ongoing debate over the universality of rights. The UN CRPD (UN, 2006) focuses on civil and political rights and some recognition of economic, social and cultural rights (Watchirs, 2005; Mensch, 2010) which can inform the policies and practices of psychiatric settings.

2) Mezzo (community-based) level recommendations and relevant implications:

Addressing stigma represents a significant implication and priority given the findings in this study at all study sites. Mental illness stigma in developing countries could be higher than in Western countries (Westbrook, Legge and Pennay, 1993; Dalky, 2012). Stigma from the community towards supported homes for people with mental disorders presents as a challenge in light of reported stigma regarding already established community based homes (Lamcja, 2016).

This area of development has implications for both funding bodies and policy makers, specifically the Albanian Ministry of Health, as well as community stakeholders in each district within which the two psychiatric hospitals operate. Staff members' feedback indicated efforts on the part of the psychiatric hospital authorities and community stakeholders towards combatting mental health stigma on a limited basis, e.g., International Mental Health Day activities; professional development events on limited basis.

Some examples of best practices to refer to are the anti-stigma/awareness raising initiatives in developed countries, for example, Australia. These efforts have led to the establishment of the Mental Health Commission and its commissioning powers, including in countries such as Australia and New Zealand (Mental Health Commission, 2014). Anti-stigma campaigns, amongst other strategies, have been found effective in challenging stigma in countries such as Canada, e.g., Bell Talk (CAMH and Bell, 2016).

The extent to which both internalized and externalized stigma impact the protection of service user rights needs to be further explored and could be led by an

Albanian academic institution in collaboration with community-based agencies, e.g., community mental health centres.

3) Macro (policy making) level recommendations and relevant implications:

The first significant implication is with regard to further deinstitutionalization of chronically ill service users which should be accomplished, yet, require adequate community infrastructure. This has significant implications for the leading role of funding bodies such as the Albanian Ministry of Health as well as for the way its budget is allocated for tertiary care institutions versus community-based mental health services. This is in response to consistent findings indicating that negative rights are violated in the psychiatric units. In addition, living conditions in overcrowded psychiatric units are leading to health inequalities in mental health treatment outcomes. Measures in pursuit of full realization of human rights should be taken to the maximum of the state's available resources *(*Nomidou, 2012).

Across the world, the deinstitutionalization process has been slow; for example, in 1978, Italy passed the Basaglia Law for closure of all psychiatric hospitals in an effort to de-institutionalize all mentally service users and offer community-based services, with access to inpatient psychiatric hospital services offered in general hospitals only. Despite its progressive stance, it was not until 2016 that Italy closed its last psychiatric hospital (Carta, 2016). Albania has an opportunity to table the deinstitutionalization process as a priority and fund it accordingly similar to what it does with regard to general health settings.

Furthermore, ratification of international conventions does not equal successful implementation of them. While the 2013 Albanian Mental Health Act embeds a capability based language, enforcement of this act via policy development by the Albanian Ministry of Health is warranted. This is in light of the "paradox of empty promises" which ratifying states exhibit in relation to their formal commitment to protect the human rights of people with mental disorders (Hafner-Burton and Tsutsui, 2005). Nomidou (2012) sees involuntary commitment as an invasive social event in the life of a person with mental disorder which calls for ethical justification, yet no ethical justification could justify depriving an individual of liberty if no law has been violated. What constitutes legal grounds for admission is variable amongst countries, which presents inherent complexities (Zhang et al., 2015). Annual visits on the part of the Ombudsman's office to Albanian psychiatric hospitals show stigmatization, discrimination and problems with admissions and release due to lack of resources to provide evaluations (US Department of State, 2014; 2017). It is therefore the role of the Albanian state to ensure protection of negative rights in these settings through a range of relevant mechanisms. An example of how this could be accomplished can be seen in the provincially funded Patient Advocacy offices in Canada, which serve as an impartial monitoring mechanism of service user rights (Centre for Addiction and Mental Health, (CAMH), 2016).

CRPD implementation is further complicated by the fact that patient human rights are inconsistently guaranteed internationally: e.g. they were not guaranteed by law until late 2000 in some countries; e.g. there is no Mental Health Act in China (Su

et al., 2012). Evidence across a few countries speaks to infringement of patient rights, such as not being giving informed consent, not being informed and not receiving protection of their privacy (Syse, 2000). There is ongoing debate about the dual role of the state in human rights protection and promotion in mental health. On the one hand the state has to protect human rights, on the other hand the state takes more rights away from mental health patients (WHO, 2005d). Legislation for the implementation of CRPD requires specific measures (Lavagnoli, 2011), and while patient rights awareness campaigns and clear complaint mechanisms to report abuses and malpractice by medical staff are recommended (Lika, 2013), the onus for denouncing abuse and corruption in the health care system should not be primarily on the service users and their family members, as it currently is as part of the Albanian Government anti-corruption initiatives.

A significant implication within the Albanian context, is the role that the public can play in denouncing payment of medical fees to the medical personnel, such as denouncement of psychiatrists accused of corruption in 2015 at the “Ali Mihali” Vlora Psychiatric Hospital (Skuqi, 2014). This speaks to legislation implementation challenges and the need for specific legislative measures on the part of the Albanian Government. In addition, the Steering Committee should develop a reporting mechanism to monitor the implementation of the Mental Health Strategy.

Furthermore, culture and attitudinal change regarding human rights protection is noted in post-communist countries, e.g. Poland (Chawla et al.,1998). This is applicable to the Albanian context, too, regarding promotion of human rights at large, and in particular in the cases of treatment of vulnerable groups in Albania (Civil Rights Defenders, 2015). For attitudes to change at the local level may take up to a generation (Walt, 1998). This slow progress has been seen in totalitarian regimes characterized by a disregard for human decency, individual dignity and humane approaches (Tomov et al., 2007), as it was in the case of Hoxha’s regime. Promotion of human rights of people with mental illnesses could be orchestrated by key stakeholders such as the Albanian Ministry of Health as well as social actors in Albania, e.g., organizations of people with lived mental health experiences; non-governmental organizations. This would be an example of the policy/change implementation combined approach (Sabatier and Jenkins-Smith, 1999).

Another implication is regarding promotion of staff members’ rights in Hospital settings. Human rights protection in health care refers to staff as well as service users (Cohen and Ezer, 2003). Staff feedback showed staff undergo monetarily punitive measures when hospital property is damaged by service users at the “Ali Mihali” Vlora Psychiatric Hospital. In addition, staff complained of lack of protection in the workplace, as well as inadequate compensation. As with other painful transitions in Eastern European countries, Albanian service users and/or their family members pursue health care informal payments in exchange for access to universally free quality of care, given the significantly compromised quality of care in the public health sector (Bonilla-Chacin, 2003; Hotchkiss et al., 2004; Vian et al., 2006), while medical staff are being seriously underpaid (Lewis, 2000; Vian et al., 2006).

Increasing doctors’ salaries, and medical personnel salaries overall, is seen as a possible solution to the phenomenon of corruption. Subsequently, the public can refuse to pay them privately (Vian et al. 2004). Albania has the lowest salary payments

in the medical field in the Balkans (Cain, 2007); according to the Albanian Institute of Statistics, a physician salary, in both general health and mental health, is no higher than: 450 euros per month (INSTAT, 2016). However, an increase of staff salary may not address the corruption that prevails in the Albanian health care system. Every attempt the government has made in the last five years to reform the sector has been met with resistance. A closer look at the physicians would show they are better off 'double dipping' in the public health care system as well as privately. They could earn a lot more via informal payments than they would earn in a well-funded health sector (Chawla et al., 1998). Based on literature findings this phenomenon has been happening in both the general health sector (Vian et al., 2004) as well as the mental health sector (Fax.al, 2015).

As a significant implication, this warrants culture change and use of culture change strategies mainly public awareness raising, e.g., campaigns regarding public's right to mental health. It furthermore places an emphasis on the involvement of consumer and family organizations in service development, policy and legislation development as well as their implementation processes (Funk, Drew and Saraceno, 2007).

On the other hand, the lack of standards and medical treatment protocols delays the health system mechanisms management improvement and the reduction of informal payments (Vian et al., 2004; 2006; Vian, 2011). The WHO QualityRights Toolkit standards, adjusted to reflect its applicability within the Albanian culture, could be embedded in the accreditation process which Albanian health care facilities/hospitals are conceptualized to undergo based on the health care reform in Albania. High level policy support for reforms usually requires the involvement of a strong coalition of stakeholder groups, including WHO office assistance, who see common interests to be achieved through change (Vian et al., 2006) as most of the corruption occurring within the health system reflects general problems of governance and public sector accountability (Vian, 2011). The anti-corruption health care initiatives undertaken by the Ministry of Health of Albania are an example of high conflict contexts which are associated with the top-down policy implementation approach (Suggettt, 2011) as these initiatives aim to bring a stop to double dipping on the part of the medical personnel (Vian, 2011). Although corruption denouncement on the part of the target groups can be seen as a low risk context which is associated with the bottom-up policy implementation approach (Suggett, 2011), this may not be the case in health care in Albania, because of the fear of reprisal while receiving medical care, as this study showed.

Therefore, the combination of the two models is needed to put an end to medical personnel extortion schemes. Strong governance in the health sector and adequate compensation for the health care personnel are examples of the top-down model (Matland, 1995); and most importantly awareness raising on the part of the public is an example of the bottom-up model (de Leon and de Leon, 2001). This could be coupled with measures which would ensure system accountability. The Albanian medical system and relevant legislation have adopted for years a paternalistic position regarding patient decision making which resembles the past communist regime's philosophy of medical care being politically imposed. Decisions by medical staff were never discussed with the patient, but the state cared for everyone (Vyshka and Kruja, 2011). Treatment refusal is a hazardous option in Albania, legally physicians are

unwilling to take risks, due to factors such as the role of proxies, i.e., family members in decision making. A service user's right to informed treatment and refusal of treatment is embedded in the Albanian Mental Health Care Act (Ministria e Shendetesise e Shqiperise, 2013), yet study data showed that the metjod by which treatment consent is obtained remains unclear. In Albania, advance directives do not apply due to the occurrence of past history which is still prevalent (Vyshka and Kruja, 2011).

In addition, there is room for inter-regional collaboration amongst Albanian stakeholders as well as regional stakeholders, e.g., country based as well as WHO led, in light of similar results of WHO QualityRights implementation in countries such as Greece, Tunisia, Lebanon and Egypt, in pursuit of inter-regional mental health awareness and education. Intergenerational and cross cultural mental health stigma requires cross cultural coordination of promotion of the rights of people with disabilities (Carta, 2016).

In conclusion, quality of care enhancement for people with mental disorders, as well as protection and promotion of their human rights is likely to occur when a combined policy implementation approach is used (Suggett, 2011) involving Albanian state actors alongside social actors, ranging from people with lived experiences to civil society actors.

SECTION 4: QUALITYRIGHTS TOOLKIT CROSS-COUNTRY COMPARATIVE FINDINGS

The QualityRights Toolkit has been used in a number of other countries, e.g., Greece, Somalia. A cross-country comparison is shown in Table 29 below (WHO, 2016).

Table 29. QualityRights Toolkit Cross-country Toolkit Comparative Results

Country	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
Albania	A/I	A/I	A/I	A/I	A/I
Afghanistan	A/I	A/I	N/I	A/I	N/I
Greece	A/I	A/I	N/I	A/I	N/I
Lithuania (Independent Living Homes)	A/P	A/P	A/P	A/P	A/I
Somalia	N/I	N/I	N/I	N/I	N/I
Tunisia	A/I	A/P	A/I	A/I	N/I

Ratings of Toolkit are as follows:

A/F: Achieved in full
A/P: Achieved partially
A/I: Achieved initiated
N/I: Not initiated
N/A: Not applicable

It is apparent that Albanian Psychiatric Hospital ratings are similar to the other countries. Violation of human rights across all 5 Themes were found in studies which utilized the WHO QualityRights Toolkit in Afghanistan (Parwiz, 2015), Egypt (Fawzy, 2015), Somalia (Currie, 2012), Greece (Nomidou, 2012), Spain (Moreno, 2010), and Tunisia (Rekhis, 2015). Theme 1 findings showed a similar poor physical state of the psychiatric hospital to in all the above stated studies. Study findings showed overcrowding of inpatient units and poor state of living environment in Afghanistan, (Parwiz, 2015), Egypt (Fawzy, 2015), Somalia (Currie, 2012), Greece (Nomidou, 2012), and Tunisia (Rekhis, 2015). Findings also showed that most service users remained hospitalized which is consistent with historical data that segregation of people with mental disorders and other disabilities in large social care and/or psychiatric institutions has been occurring in most countries across the world (Wing and Brown, 1970; Desjarlais et al, 1995; Thornicroft and Tansella, 1999; 2004).

The state of the psychiatric settings from Vlora and Elbasan compared poorly with general health settings, similar to findings from all above stated studies. Lack of service user privacy and lack of freedom of movement within the hospital reported in this study, was consistent with findings from all above noted studies. Service users' choices in the Albanian psychiatric hospitals as they pertained to the clothing they could wear were limited since they were mandated to wear hospital clothes; this finding was different from the findings of the above stated studies, which may be explained by the long standing legacy of communist Albania's psychiatry (Weinstein et al., 2000).

With regard to Theme 2, study findings in Albania showed that the admission criteria of the psychiatric hospitals in Elbasan and Vlora did not present with any admission barriers; this is different from Afghanistan's Psychiatric hospital which accepts service users with family members only (Parwiz, 2015). This difference may be explained by the attempts made by the Albanian Ministry of Health to enhance access to care in psychiatric hospitals in the last 10 years (Ministria a Shendetesise e Shqiperise, 2013), as well as attempts to meet requirements for gaining the candidacy status to join the EU (Carta, 2014; Kryeministria, 2014; EU, 2018).

However, a lack of adequate clinical members of staff, e.g., psychiatrists, psychologists including limited presence of evidence-based treatment protocols were noted similar to findings from all the other studies. This could be a reflection of the degree to which positive rights/2nd generation rights, as embedded in Theme/Standard 2 (WHO, 2012b), are contingent upon mental health service funding availability (WHO, 2008b). Mental health service funding is also more limited in developing countries than in developed countries (Parker, 2007). This is the case of Albania and its economic development (Tomini et al., 2013; 2015), and other countries, e.g., Tunisia (Kheris, 2015).

Lack of advance directives was found in this study as well as in the other studies above. This included lack of any CRPD knowledge in these psychiatric hospitals. Lack of any mechanisms to express service quality feedback was noted in these countries with the exception of the study in Greece (Nomidou, 2012). This is different from Vlora and Elbasan where only a small number of service users and family members were aware of the option to speak to senior management staff and, although the contact information of Albania's Ombudsman's office was posted and reported, some expressed a reluctance to use these channels as they were afraid of reprisal. This difference within the Albanian context may be explained by a) the long standing legacy of the communist regime, during which Albanians suffered reprisals for speaking freely (Amy, 2017) and the fact that Vlora and Elbasan psychiatric hospitals host Communism political dissidents (Muzeu i Memories, 2014); b) Albania's efforts to gain the EU membership candidacy status and its associated criteria, e.g., increased system accountability, including in health care (Carta, 2014; Kryeministria, 2014; EU, 2018).

Similarly, lack of recovery plans, inconsistent completion of service user files, limited creation of support networks, were noted in the other countries where the Toolkit was implemented, as well as in Albania. The length of stay of inpatient service users in Vlora and Elbasan was the longest in comparison to the other studies. In the Afghanistan study, service users were sent to mental health asylums in Afghanistan post discharge from the psychiatric hospital (Parwiz, 2015). These results were consistent with Noumidou (2012)'s findings in a study in Greece as well. In addition,

the presence of paternalistic attitudes on the part of physicians and medical personnel were noted in Vlora and Elbasan psychiatric hospitals. Such paternalistic attitudes do not reflect the existence of a dialogue between people with lived experiences and those with professional-based knowledge (Boevink, 2017). This dialogue is essential given the role that human rights in the medical field have in the patient-provider relationship (Cohen and Ezer, 2013) and the responsibility on the part of the physicians to bring human rights into health (UN, 1999). Study findings from Vlora and Elbasan showed availability of psychotropic medication in accordance with the national essential drug list, similar to findings from the above-stated studies.

With regard to Theme/Standard 3, study findings from Vlora and Elbasan psychiatric hospitals were consistent with findings from studies in Afghanistan, Egypt, Tunisia, Somalia and Greece regarding service user lack of knowledge of their rights, and lack of choice regarding treatment preference. Although formal procedures to obtain legal consent exist in Vlora and Elbasan psychiatric hospitals, unlike in other countries, e.g., Afghanistan and Egypt, the methods used to obtain such consent are unclear in light of reported service user resistance to consenting within the first 48 hrs post admission. However, written evidence of such consent in service user files was present. Violation of service user legal capacity on involuntary admission grounds was also seen in Vlora psychiatric hospital. No legal mechanism was initiated in the case of involuntary admitted service users. Supported decision making is non-existent and replaced by substitute decision making processes, where applicable, in these hospitals. Unlike these findings in Vlora and Elbasan, in other studies, e.g., in Afghanistan (Parwiz, 2015) and Egypt (Fawzy, 2015), all service users were involuntary admitted and no legal platform existed to protect service user legal capacity. The presence of formal involuntary admissions guidelines in Albania's psychiatric hospitals could be explained as part of the Mental Health Care Reform carried out by Albania's Ministry of Health (Ministria e Shendetesise, 2013) along with its attempts to meet requirements for gaining candidacy status to join the EU (Carta, 2014; Kryeministria, 2014).

With regard to Theme/Standard 4, physical abuse of service users by staff, chemical and physical restraining of users by staff, use of seclusion rooms, as well as physical abuse between service users and physical abuse of staff by service users, were found in Albania's psychiatric settings, similar to findings in other countries, e.g., Afghanistan and Egypt respectively (Parwiz, 2015; Fawzy, 2015). No formal body was found in any of these settings to monitor cases of abuse towards service users. Albania, similarly to Afghanistan (the Human Rights Commission) (Parwiz, 2015), has the Ombudsman's office which oversees the protection of service users' human rights and carries out an annual inspection of these settings.

Similar to study findings in Greece (Nomidou, 2012), findings from both Vlora and Elbasan showed that chemical restraining is used particularly during the admission process, of both voluntary and involuntary service users; bed tying was also used to restrain service users who did not respond to verbal de-escalation strategies offered by members of staff. While the mechanism used to obtain service users consent in Vlora and Elbasan within 48 hrs remains a mystery, it consequently has treatment implications. Involuntary treatment, e.g., physical restraining, use of mind-altering drugs without the user's consent and deprivation of liberty, constitutes ill-treatment based on the CRPD (UN, 1999; 2007). Such practices are justified under the umbrella of presence of/potential

for danger; the use of these practices vary amongst countries depending on their Mental Health Acts (Cullen-Drill and Schilling, 2008; Cairns et al., 2010; Zhang et al., 2015). For changes in practices to begin, changes in mental health legislation are warranted as violation of negative rights affect service user ability to enjoy their other overall rights (Dudley, Silove and Gale, 2012; Nomidou, 2012), including positive rights as captured in Themes 1, 2 and 5.

Regarding Theme/Standard 5, the presence of limited community infrastructure to discharge service users to, was reported in the case of Vlora and Elbasan psychiatric hospitals in Albania. These findings are particularly similar to the findings reported in the studies mentioned above, e.g., Egypt (Fawzy, 2015). The study in Lithuania showed attempts to support discharge of psychiatric service users to independent living homes (Grigaitė, 2017). However, there are disadvantages in that the grouping of people with disabilities into designated apartments in residential compounds exclusively targets these people with disabilities (Angelova-Mladenova, 2017).

Family members did report social work provision of information regarding access to disability support to service users in Vlora and Elbasan, which was different from the findings in some other countries, e.g., Egypt. Stigma was reported on the part of members by staff regarding service user capacity to vote, similar to findings in Egypt (Fawzy, 2015). Both Albanian and Egyptian hospitals hosted former political dissidents.

To conclude, Albania's rating of the Toolkit's standards are similar with ratings from other countries, where the Toolkit has been launched, except for Somalia's which rated lower than all above noted countries. Factors such as the lack of funding and lack of community infrastructure to support the deinstitutionalization process of service users; as well as non-compliance, on the part of the mental health institutions, with national legislation aiming to protect negative rights are two key variables which appeared to influence standard ratings across countries where the Toolkit has been implemented.The extent to which these factors and other factors impact the Toolkit ratings requires further attention in future studies.

SECTION 5: SUMMARY

This section provided a discussion of the main findings as they pertain to the questions this study raised, considering these globally, in terms of the quality of care of people with mental illness, and the protection and promotion of their human rights.

Study findings showed that protection of both negative and positive rights has been initiated in study psychiatric units in Vlora and Elbasan, and met to a limited extent in the Surgery Units in these cities. A pronounced lack of funding of psychiatric services was reported as a key factor which impacts quality of care and violation of the human rights of service users in psychiatric settings. Stigma as a past legacy of Communism, as well as lack of awareness of service user rights, primarily, on the part of staff, were reported as factors which may impact lack of compliance on the part of the psychiatric units with human rights legislation in Albania. Corruption was reported as a key factor which impacts quality of care and human rights protection in surgery units. Recommendations were provided regarding protection and promotion of positive and negative rights. A cross-country comparison of WHO QualityRights Toolkit findings was presented.

To conclude, human rights protection in health care, can be seen as an inseparable process of societal development rather than just a dichotomous division between positive and negative rights and consequently their protection processes. This is best understood in light of the ongoing debate regarding the nature of human rights, the cultural and socio-economic development of a country, along with the variation in mental health legislation across countries.

CHAPTER VII: A CRITIQUE OF THE WHO QUALITYRIGHTS TOOLKIT AND STUDY LIMITATIONS

SECTION 1: A CRITIQUE OF THE WHO QUALITYRIGHTS TOOLKIT

1.1: WHO QUALITYRIGHTS TOOLKIT STRENGTHS

Universality regarding assessment of civil and political rights as embedded in Themes/Standards 1, 3 and 4 is the main strength of this study which is elaborated below. The high validity of the Toolkit is a second strength.

1.1.1: UNIVERSALITY OF CIVIL AND POLITICAL RIGHTS

With regard to Themes/Standards 1, 3 & 4, the QualityRights Toolkit appears to measure directly aspects such as: living conditions of service users; a person's right to exercise legal capacity and their right to personal liberty and security, as well as freedom from abuse, torture, neglect and punishment. There is unanimous international agreement on the importance of a person's protection from any form of abuse and/or neglect, as reflected in Toolkit Theme/Standard 4. As findings showed, the QualityRights ToolKit specifically revealed cases of abuse and neglect in psychiatric units, as well as service user neglect in surgery units in Albania. Specifically, it showed liberty infringement in the case of involuntary admitted service users, including cases where legal proceedings regarding such cases were completely violated in the "Ali Mihali" Vlora Psychiatric Hospital. In the surgery units, it exposed the physician extortion schemes as examples of abuse and neglect towards service users.

In addition, the QualityRights Toolkit revealed the extent to which people's right to legal capacity and right to personal liberty and security is infringed in both psychiatric units included in this study. This applies to the degree to which restraints are used and the questionable practices related to how service user voluntary admission consents are obtained; it includes initiation of psychiatric treatment of involuntary admitted services users whose legal capacity is violated at the "Ali Mihali" Vlora Psychiatric Hospital.

1.1.2: INSTRUMENT HIGH VALIDITY

The data triangulation speaks to high content validity (Creswell, 2014). The Toolkit refers to the measurement of quality of care as it pertains to Themes/Standards 2 and 5 which are a reflection of socio-economic/civic rights, while it also measures the protection of human rights as it pertains to Themes/Standards 1, 3 and 4.

1.2: WHO QUALITYRIGHTS TOOLKIT LIMITATIONS

In spite of the usefulness of the Toolkit in highlighting concerns with civil and political rights, it also has limitations as described below.

1.2.1: UNIVERSALITY REGARDING SOCIO-ECONOMIC RIGHTS

The QualityRights Toolkit presumes that all rights are universal, hence, it is expected that each country respects, promotes and protects human rights in health despite the fact that civil and political rights have received far more attention nationally and internationally as they address the protection of citizens from governments (WHO, 2012b).

Attempting to explore and/or assess protection of human rights and quality of care in psychiatric units in Albania using the QualityRights Toolkit, based on a universal framework, represents a challenge. There are three main reasons for this:

1. The debate over the nature of human rights still continues internationally and is reflected in the range of human rights conventions/treaties, and subsequently the varying degree of their endorsement via country legislation and health care practices;

2. The quality of health care in a country being largely dependent on the GDP of that country and specific funding of the health care system, with serious implications from a health inequity standpoint;

3. Health, being socially constructed, represents a challenge which any assessment tool will need to reconcile, the QualityRights Toolkit included.

Regarding reason 1, it is important to examine the application of the QualityRights Toolkit in the context of standards which encapsulate civil and political rights, and socio-economic rights. How the QualityRights Toolkit performs in relation to assessing civil and political rights, which are embedded in standards 1, 3 & 4 and whose core notion is “freedom from abuse and neglect” and in relation to assessing socio-economic rights, whose core notion is “freedom to” quality health care services, as embedded in standard 2 (Right to the Highest Attainable Standard of Care), requires careful examination. The QualityRights Toolkit appears to assess civil and political rights effectively due to their uncontested universal nature, but is less effective regarding measuring the socio-economic/positive rights.

Despite the efforts of the WHO to internationally universalize strategies for mental-health care delivery (Zhang et al., 2015), there is a great degree of variability of regulations for involuntary admission and treatment of patients with mental health disorders across countries. This questions the applicability of the QualityRights Toolkits to assess liberty, as it applies in cases of involuntary admissions.

According to the Albanian Mental Health Act (Ministria e Shendetesise e Shqiperise, 2013), the presence of a mental disorder and danger to self and others sets conditions for one’s involuntary admission. Italy is a solitary example whereby

neither danger to self or others serves as a reason for involuntary admission to a psychiatric hospital, just suffering from a mental disorder does (Zhang et al., 2015; Carta, 2016). The deprivation of liberty safeguards, at a global level, have been criticized for their complexity and unclear interfacing with mental health acts (Cairns et al., 2010). Given the varying legislative landscape across countries, applying universal standards related to admissions assessment or deprivation of liberty is problematic. Even within general health care units, the universal nature of the concept of service user refusal to treatment is questionable. Albania builds on a specific past legacy where the state predominately dictates the health care needs of the population (Vyshka and Kruja, 2011).

With regard to reason 2, the universal nature of the Toolkit is a limitation in itself; Theme/Standard 2 requires special attention and interpretation of the results as cultural systems, as well as the political landscapes, are an important part of assessment processes (Adenpole, Whitley and Kirmayer, 2012). The right to health is based on positive international law which seems to be based on moral principle grounds. Health and health care are examples of social constructions which are determined by power relations (Yamin, 2017). Claiming that health, including health care, is a right implies governments must create the economic conditions to support a health system that is fair and responsive to people's health needs despite their economic potential (Gable and Gostin, 2009; Ruger, 2010).

Although health is seen as a necessary condition for quality of life, it is found to be impacted by a series of factors, most importantly the unaffordability for some of attending to health related needs. This refers to the interconnection between health and one's life circumstances, otherwise called social determinants of health, whose variability is seen as a predictor of health inequities amongst countries and within countries (WHO, 2017b). Poverty, in particular, is seen as a perpetuating factor of poor health particularly in low income countries (Tomini et al., 2015; WHO, 2017b). This is best understood in light of how the QualityRights Toolkit universality applies to the assessment of standard 2: "The Right to the Highest Attainable Standard of Health Care". The universality of this right is debatable given the disproportionate financial power that countries have globally. In Albania's case, only 5.9% of its GDP is spent on health care versus 8.5% spent in the EU countries (WHO, 2015; OECD, 2017) mental health in Albania receives just 4.1% of its overall health care funding (Demi and Voko, 2014). Poor funding of mental health services is similar to the 'Cinderella services' phenomenon in the UK whereby mental health services are not considered a priority (Orr, 2013).

Therefore, universalization of the "Right to the Highest Attainable Standard of Health Care" as a key right embedded in the QualityRights Toolkit presents with limitations. Instead, the approach should focus on the discourse on the right to health being seen as a social justice matter, which speaks to the interconnection between the social and power inequities in societies (Farmer, 2003) and whereby marginalization of any kind, i.e., gender, income, disability, exposes people to higher risk of poor health (Carter, Hanes and MacDonald, 2017; WHO, 2017b).

Differently put, "….the democratic legitimacy of the right to health and the application of human rights in health matters depends upon reforming international legal frameworks and strategies to explicitly address pathologies in economic as well

as political power, and promoting meaningful deliberation in health systems over *inter alia* the contours of an enforceable right to health" (cited in Yamin, 2017, pp.2)

With regard to reason 3, health is socially constructed (Conrad and Barker 2010) and there are Albanians who do not hesitate to pay-out-of pocket to access quality of care despite the financial implications. As this study showed, some family members in general health units preferred access to brand medications rather than their loved family members accessing the generic medication provided by the hospital, which required offering 'tip'/(bakshish) to medical personnel. This may be because having good health is socially constructed as of high value within the Albanian culture, as reflected in the expression: "If you don't have good health, you don't have anything else in life", as it is perceived to impact one's overall quality of life. On the other hand, the high payments out-of-pocket amongst Albanians have a catastrophic financial impact on them with a direct impact on their quality of life (Vian et al., 2004; Vian, 2011; Tomini et al., 2015) and therefore, paradoxically, their health.

1.2.2: WESTERN INFLUENCE

Human rights are considered to be a Western concept (Donnelly, 1982); it is claimed that the UN Universal Declaration of Human Rights is influenced by Western countries and their stakeholders (Waltz, 2002). This claim raises questions about the universalism of human rights to all cultures. It seems that the development of the concept of human rights lacks influence from non-Western political and cultural climates (Donnelly, 1982) and draws from the Western views, e.g., the Euro-American concepts of self which view the person as individualistic or egocentric (Bellah et al., 1985; Johnson, 1985) and capitalizes on liberal democracy and political and cultural liberties (Huntington, 1996).

In addition, the QualityRights Toolkit draws from the recovery model, a Western construct, which is influenced by the recovery movement, which in itself stems from the civil rights, independent living and disabilities movement (Davidson et al., 2009). Subsequently, its main principles advocate for independent living, and see people with disabilities as experts in their life who, with or without any input from others (Bellah, 1985), can take the lead in service planning (Fleischer, 2001). Yet, the recovery model is impacted by Neo-Liberalism as it removes the state from responsibility to provide services for its citizens, e.g., the marginalized people (Cohen and Ezer, 2013). Furthermore, living customs are context based, culturally, economically and politically, which has a direct impact on trajectories of illness, adaptation modes, treatment interventions and the role service users' play in the recovery process, ultimately impacting the outcome (Adenpole, Whitley and Kirmayer, 2012).

The characteristics of individualism run counter to the collective well-being profoundly advocated for in collective and patriarchal cultures such as Albania's (Kaser, 2000; Sawicka 2013). The tension between individualism and collectivism is seen regarding the service users' role in their treatment decision making process. The QualityRights Toolkit application in the psychiatric units revealed that the service user had no role in decision making, which is not mitigated by using family members as proxies. It appeared that in such units, most service users are abandoned, yet study results showed that the small number of family members interviewed in this study

maintained frequent (weekly) contact with their loved ones receiving care in these hospitals; in contrast, in Surgery Units all family members appeared actively present and proxies in decision making. While service user participation in decision making is assessed on the basis of the universality of this concept, as reflected in the QualityRights Toolkit, self-decision making, within a clan-based (Doll, 2000), collectivist and patriarchal culture, guided by canonistic laws (Bardhoshi, 2012), such as the Albanian culture (Kaser, 2000; Sawicka 2013), presents with challenges. The Toolkit aims to measure self-sufficiency primarily rather than recognizing the role that other proxies play in Albania, which are found to be of significant value in general health care (Vian at al., 2006; Vian, 2011). Even though Albania leans towards Western ideology, its customs are highly influenced by collective Asian and Islamic ideals as Islam is the dominating religion (Sawicka, 2013). Within collectivist contexts, the person sees himself/herself in relation to others (Kitayama and Park, 2007) and what may constitute recovery in Western countries, may be differently constructed in collectivist countries, where collective living is a predominant form of living, as was and is the case in Albania.

1.2.3: INSTRUMENT RELIABILITY

It is safe to conclude that the WHO QualityRights Toolkit's reliability in measuring protection of human rights to health across all five standards presents with limitations, given all the aforementioned reasons as it applies to the key question which this study aims to address within the Albanian psychiatric settings. Its observer reliability (Trochim and Donnelly, 2007) provided consistent data gathered by all committee members in relation to assessing protection of 1st generation/civil and political rights embedded into Themes/Standards 1, 3 and 4, and less so in relation to Themes/Standards 2 and 5. Its test-retest reliability as well as internal consistency reliability (Creswell, 2014) remain to be seen particularly considering the mental health legislation variability across countries.

For the WHO QualityRights ToolKit to serve as a policy solution regarding quality of care and human rights protection in health care, its application warrants serious consideration of the complex socio-economic and political landscape human rights are asserted in.

SECTION 2: STUDY LIMITATIONS

This study is a modest attempt at exploring the state of human rights in psychiatric hospitals in Albania using the WHO QualityRights Toolkit for the first time. However, the study suffered from several limitations. Firstly, it is linked with how to define human rights based on the international debates earlier discussed, the WHO QualityRights Toolkit universality principle, and subsequently the institutional and contextual complexities which surround human rights. It is concluded that human rights in mental health care are a reflection of societal development rather than just a dichotomous division between positive and negative rights and consequently their protection processes require local contextualization of such rights.

Secondly, this study presents with internal validity limitations. This stems from the study's small samples whereby less than 10% of all service users were interviewed at the 'Ali Mihali" Vlora Psychiatric Hospital, and less than 4% of all service users were interviewed at the 'Sadik Dinci' Elbasan Psychiatric Hospital. Sampling related challenges pertained to the inability to select in a randomized way, which presents as a bias issue (Creswell, 2014), as well as the inclusion of service users with brain injuries, and the inability to collect data on all involuntary admitted service users. Sample sizing limitations do present with generalizability related issues (Creswell, 2014) and call for future large scale research studies. In addition, this study presented with external validity limitations as study participants' views may have been influenced by their fear of reprisal, which can lead to information bias (Trochim and Donnelly, 2007). This is further complicated by the hospital pressures on staff not to disclose problems, i.e., number of involuntary admitted service users, as Albania continues to experience pressures arising from EU candidacy and compliance with human rights standards requirements (EU, 2018).

Another limitation to the internal validity was with regard to data collection (Trochim and Donnelly, 2007; Creswell, 2014): it was not possible to make audio recordings including review of service users charts to determine adequacy of medication type and dosage. Neither hospital allowed for audio recording of the interviews which presents with data accuracy issues, despite every effort made on the part of the interviewers to accurately write all study participants' responses and analyse them qualitatively.

Thirdly, despite efforts made on the part of the interviewers to minimize the effect of the Hawthorne effect (Roethlisberger and Dickson, 1939), this study may have presented with external validity limitations during the unannounced visits at the hospital sites. Observation differences regarding staff attitudes towards service users in Psychiatric units during announced and unannounced visits could be accounted for by the presence of the Hawthorne effect and its impact on data collection accuracy.

Finally, assessment of factors, e.g., institutional, which impact human rights protection and quality of care is recommended to measure any attitudinal changes as well as service improvement changes, particularly the promotion of service user human rights and compliance with standards of care. Fine-customization of the WHO QualityRights Toolkit is needed in order to effectively assess rights in collective societies.

SECTION 3: SUMMARY

This chapter provided a critique of the WHO QualityRights Toolkit based on its application within the Albanian environment. A key strength of the Toolkit rests on its emphasis of the universalization of the civil and political rights: freedom from torture and abuse. However, limited universalization of the civil and political rights and the Toolkit's inherent limited assessment function in the case of the varying mental health legislation with regard to involuntary grounds for admission were addressed. On the other hand, universalization of socio-economic rights as embedded in Themes 2 and 5 as well as its Western influences whose focus is on individualism and independent living, contrary to Albanian collectivist culture characteristics, were considered a limitation of the Toolkit within the Albanian context. A critique of the Toolkit's validity and reliability was also offered.

Last, it provided a summary of the study limitations. The key limitations are: from the use of a small sample; the inability to select service users in a randomized way; the fact that study participants' views may have been influenced by their fear of reprisal. Further assessment of the interplay of factors which impact human rights protection and quality of care in psychiatric settings is recommended.

CHAPTER VIII: CONCLUSIONS AND STUDY CONTRIBUTIONS

If the saying that 'Iliret in Ilyria" were indeed the ancestors of Albanians (Sawicka, 2013), whose meaning is "to be free" it is perhaps ironic that Albanians have significantly struggled to pursue their freedom, as well as the rights that freedom is associated with. Albania and Albanians were invaded for many years; the longest was the Turkish invasion which lasted for 5 centuries, until the declaration of Albania's official Independence Day in 1921. This was followed by invasions in World War I and World War II and 45 subsequent years of the Communist regime. This history, coupled with the predominantly collective culture that prevails in Albania (Kaser, 2000; Sawicka, 2013) means that it is understandable that the country faces challenges as it pursues freedom and attempts to capitalize on the benefits of this freedom.

The main underlying assumption of this study is that the fall of Communism in Albania has generated economic growth, an improvement of human rights and ratification of the UN CRPD. However, the extent to which such improvements have been translated into an improvement of human rights for people with mental disorders in psychiatric units was unknown, warranting the need for this study.

The first contribution this study makes is that it attempts to address two key questions in light of the fascinating case of Albania and its past Communist regime legacy: a) Do the Albanian Inpatient Psychiatric Units at the 'Ali Mihali' Psychiatric Hospital and the 'Sadik Dinci' Elbasan Psychiatric Hospital meet Human Rights standards? b) To what extent does the WHO QualityRights Toolkit accurately measure human rights protection within the Albanian perspective?

There were additional questions which I explored as follows: 1) "Are negative rights met in the Psychiatric Inpatient Units"? 2) "To what extent can positive rights, within the mental health context, be met in a developing country such as Albania"? 3) "How does poor quality of care become a human rights issue in Albania's psychiatric units?" 4) "Are there any differences in human rights protection between inpatient psychiatric services and surgery inpatient units? If so, what factors/themes may speak to any reported differences"?

This study used an evaluative mixed-methods triangulation study design with an in-between method of triangulation (Creswell, 1994; 2014) which focused on gathering qualitative semi-structured one-on-one interviews, qualitative observations and records and reviews of relevant policies/guidelines. These key components shaped this research and its final outcomes.

Study findings from the two psychiatric units were compared against the Surgery Inpatient Units at Vlora General Hospital in Vlora city and Elbasan General Hospital in Elbasan city because of the underlining assumption of difference in quality of care and human rights protection between psychiatric settings and general health settings (WHO, 2012b).

The study reported violation of negative rights/first generation rights as they pertain to Themes/Standards 1, 3 and 4, and concerns about the limited extent to which positive/second generation rights, as captured in Themes 2 and 5, were met at both

psychiatric hospitals. These findings were noted despite improvements made regarding protection of service user negative and positive human rights post 1991, the year of the Communist regime collapse, e.g., renovated hospital buildings, introduction of psychological services and Albania's ratification of the UN CRPD in 2013 (UN, 2016). Violation of human rights across all 5 Themes reported in this study, were consistent with findings from previous studies which had utilized the WHO QualityRights Toolkit in Afghanistan (Parwiz, 2015), Egypt (Fawzy, 2015), Greece (Nomidou, 2012), Spain (Moreno, 2010), and Tunisia (Rekhis, 2015).

With regard to negative rights, Theme/Standard 1 findings showed a poor physical state of the psychiatric hospitals, similar to findings in all the above mentioned studies, with the exception of the newly built acute units in Vlora. The state of the psychiatric settings from Vlora and Elbasan compared poorly with Surgery Units, similar to findings from all the other studies. Again, consistent with findings from the other studies mentioned above, service users' choices and freedoms were limited in the Albanian psychiatric hospitals as well. Improvements regarding life essentials such as food, were noted in both hospitals.

Violation of negative rights was noted under Theme/Standard 3 findings as well. Staff stigma and lack of staff understanding of service user human rights were a key qualitative theme emerging in this study**.** For example, stigma on the part of staff as it pertains to service user rights to exercise their legal capacity and express preferences regarding treatment options, perpetuates discrimination which is a human right issue, and therefore compromises the quality of care offered, which has a direct impact on service user recovery, health and quality of life (WHO, 2012; Jacob, 2001; Ritsher and Phelan, 2004). This explains how poor quality of care becomes a human rights issue, and consequently impacts the quality of life, in the Psychiatric Units in Vlora and Elbasan, which in return, affects the service user ability to pursue and enjoy their other human rights, for example the right to live independently (Funk et al., 2010; Angelova - Mladenova, 2017).

Such interconnection is particularly problematic when considering that the length of stay of inpatient service users in Vlora and Elbasan was the longest in comparison to other studies mentioned above, and longer than 180 days, which is considered an extensive length of stay for service users with serious mental illness, e.g., schizophrenia (Jacobs et al., 2015).

Formal legal consent obtaining procedures exist in Vlora and Elbasan psychiatric hospitals, unlike in other countries, e.g., Afghanistan, Egypt, yet methods used to obtain such consent are unclear in light of reported service user resistance to consenting within the first 48 hours post admission. However, written evidence of such consent in service user files was present. Violation of service user legal capacity on involuntary admission grounds was also seen in Vlora psychiatric hospital. No legal mechanism was initiated in the case of involuntary admitted service users contrary to the presence of formal involuntary admissions guidelines in Albania's psychiatric hospitals as per the Albanian Mental Health Act.

Other violations of negative rights were supported by Theme/Standard 4 findings: suggestion of physical abuse of service users by staff (at the "Ali Mihali" Inpatient Psychiatric Unit in Vlora); chemical and physical restraining of service users

by staff; use of seclusion rooms; physical abuse amongst service users; as well as physical abuse of staff by service users at both psychiatric hospitals. These findings are consistent with findings from studies in all other countries, e.g., Egypt, where the Toolkit has been launched, and are in violation of the Albanian Mental Health Act. It is clear that even in the case of a CRPD signatory state such as Albania, protection of human rights is not guaranteed.

No formal body was found in either Vlora or Elbasan psychiatric settings to monitor cases of abuse towards service users. Albania has the Ombudsman's office which oversees, on a limited basis, the protection of service users' human rights and carries out an annual inspection of these settings. Lack of any CRPD knowledge in these psychiatric hospitals was also noted.

Similar to study findings in Greece (Nomidou, 2012), findings from both Vlora and Elbasan showed that chemical restraining is used particularly during the admission process, of both voluntary and involuntary service users; bed tying was also used to restrain service users who did not respond to verbal de-escalation strategies offered by staff. Such practices are justified under the umbrella of presence of/potential for danger and vary amongst countries depending on the Mental Health Acts of a country (Zhang et al., 2015; Cairns et al., 2010). Violation of negative rights affect service user ability to enjoy their other overall rights (Dudley, Silove and Gale, 2012; Nomidou, 2012), including positive rights as captured in Themes/Standards 2 and 5, and consequently their quality of life.

With regard to positive rights, Theme/Standard 2 study findings in Albania showed that the admission criteria of the psychiatric hospitals in Elbasan and Vlora did not present with any admission barriers; this is different from Afghanistan's Psychiatric hospital which accepts service users with family members only (Parwiz, 2015). This difference may be explained by the attempts made by the Albanian Ministry of Health to enhance access to care in psychiatric hospitals in the last 10 years (Ministria a Shendetesise e Shqiperise, 2013), including Albania's attempts to meet requirements for gaining the candidacy status to join the EU (Carta, 2014; Kryeministria, 2014) as well as opening accession negotiations process in June 2019 (EU, 2018).

However, a lack of funding was revealed as a key qualitative theme; this led to a lack of clinical resources, e.g., psychiatrists, psychologists, etc. Limited presence of evidence-based treatment protocols were noted. This could be a reflection of the degree upon which positive rights as embedded in Theme 2 (WHO, 2012b) are contingent upon mental health services funding availability (WHO, 2008b), which is partly influenced by the socio-economic development of a country (WHO, 2008b). Albania is characterized by slow economic growth (Tomini et al., 2015), and it can be concluded that the degree to which positive rights are met in the psychiatric units in Vlora and Elbasan is limited. The extent to which this situation affects service user health outcomes could be explored in future studies.

Unlike in the Psychiatric Inpatient Units, a key qualitative theme in the comparative Inpatient Surgery Units in Vlora was the presence of corruption, evidenced by: bribery of surgeons as a condition for accessing care/surgery; as well as lack of intravenous supplies at the surgery unit in Elbasan city. This difference could be explained by the high prevalence of corruption in health care, amongst other

sectors, in former Eastern Europe countries (Vian, 2011), e.g., Poland (Chawla et al.,1998).

Positive rights violations were seen under Theme/Standard 5, which referred to deinstitutionalization/discharge constraints due to the limited presence of community infrastructure to discharge service users to in both cities. Family abandonment was also noted at both hospitals. Family member stigma and abandonment was also reported in WHO QualityRights Toolkit in Egypt (Fawzy, 2015).

Enhanced funding of surgery units, uncompromised service user liberties while in care, as well as adequate quality of care in the Surgery Units were some key differences between the psychiatric and surgery units. Family member involvement in the service user treatment journey was reported as a key factor contributing to service user human rights protection in the Surgery Units. Whereas in psychiatric units it was the presence of stigma which was reported to negatively influence quality of care, in surgery units it was the presence of corruption which was reported as detrimental to service user quality of life.

The second main contribution of this study in Albania is that it views human rights as a process of development rather than just a dichotomy of positive and negative rights. It offers a critique of the WHO QualityRights Toolkit, the first of its kind, with a critique of the universal framework which the QualityRights Toolkit adopts. It speaks to the lack of quality of care and the limited extent to which positive human rights are met as a reflection of economic underdevelopment as seen in Themes 2 and 5. Despite the key role that physicians and medical personnel at large play in quality of care provision within psychiatric inpatient units, and their medical ethics guiding principles of autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress, 2001), promotion of quality of care and human rights protection cannot be seen as separate from the health disparities interdependencies that exist (Yamin, 2017)**.** In addition, human rights are intrinsically interconnected with the role that the state and its institutions play, translated in the varying human rights legislative platforms different countries develop. Attempting to unify and universalize, at a global level, these legislative platforms is a challenging undertaking. It is similarly challenging to presume that all rights are universal at a time when the international debate about the nature of human rights still continues. The Toolkit's philosophical influences with an emphasis on individualism and independent living which run counter to the core values of collective cultures, was another limitation noted.

From a methodological standpoint, data and researcher triangulation as reflected in the Toolkit speaks to high instrument validity. Its reliability, however, presents with limitations because of the points mentioned above.

The third contribution the study makes, from a methodological standpoint, is the use of an evaluative mixed-methods triangulation study design with an in-between method of triangulation (Creswell, 1994) to help collect data from multiple sources. The design was based on the thematic analysis of interviews held; this was different from all other QualityRights Toolkit studies in other countries. This study draws from both the social constructionist view point, in which views and perceptions and attitudes are locally constructed, including human rights *(*Watchirs, 2005; Mensch, 2010*),* as well as

from critical realism according to which reality and its causal factors have tangible consequences for human beings (Bhaskar, 1975; Archer, 1995).

This study presents with limitations. It captures a small sample size from the overall number of service users residing in inpatient psychiatric units. In addition, interviewees from all three study groups expressed fear of reprisal, e.g., staff members interviewed expressed concerns regarding losing their employment if their anonymity was disclosed. Data on the number of involuntary admitted service users was not released by the hospital, nor was data on the number of service user abuse incidents released in Vlora and Elbasan. Establishing the extent to which ratings in levels of awareness of human rights differ between the psychiatric settings and general health settings for all study groups, as well as factors, e.g., stigma, accounting for such differences, would provide grounds for fertile research.

This study points at a few recommendations and implications for practice. Calling for state responsibility to ensure that psychiatric facilities are monitored independently by impartial entities (Nomidou, 2012) is a key recommendation made by this study. The role that social actors, other than state, can play in promotion of human rights in health should also be considered (UN, 1999). While the general shift by WHO is to further advance the deinstitutionalization of chronic service users, to community-based mental health care, with the aim of promoting freedom from inhumane treatment, equality and rights to an independent life (WHO, 2003; Stein, 2007; Funk et al., 2010), the extent to which the Albanian society is prepared to see people with mental illnesses integrated into communities remains unknown, given the long standing legacy of stigma and discrimination towards people with mental disorders in Albania (Ministry of Health of Albania, 2013). In addition, for changes in practice to begin, changes in the Albanian Mental Health Act are warranted with regard to clearly delineating the grounds under which chemical restraining could be used in general, and specifically during the admissions process. This includes both voluntary admitted and involuntary admitted service users.

With regard to the reported corruption in Surgery Units, a combination of top-down and bottom-up approaches is needed to put an end to medical personnel extortion schemes in Albania. Strong governance in the health sector and adequate compensation for the health care personnel are examples of the top-down model; and, most importantly, awareness raising on the part of the public is an example of the bottom-up model,

Even if Albania's economic challenges are resolved in the future, so that availability of resources no longer presents a major barrier in mental health services, Albania still has to overcome the cultural legacy of Communism. For attitudes to change at the local level may take up to a generation (Walt, 1998). This change is particularly slow in former totalitarian regimes which are characterized by no regard for human decency and individual dignity (Tomov et al., 2007). Such change would involve a re-examination/re-construction of human rights at large, and most specifically in the context of people with mental illnesses. Therefore, human rights protection in health care can be seen as a process of development rather than just a dichotomy.

For the WHO QualityRights ToolKit to serve as a policy solution regarding quality of care and human rights protection in health care, its application warrants

serious consideration of the complex socio-economic and political landscape human rights are asserted in. As the international debate over the nature of rights and institutionalization of such rights still continues, the findings of this study point to the need for the adoption in Albania of a combined policy implementation approach (Suggett, 2011). Introduction of service user rights, ratification of the CRPD, and launch of Albanian authorities' mental health strategy and relevant action plans have been an example of deploying a top-down policy implementation approach, which is an example of a path dependency policy change model (Wilsford, 1995). A combined model policy implementation strategy would support an increase in awareness of human rights amongst staff as well as family members and service users. The effectiveness of such a strategy will have to be explored.

REFERENCES

Adeponle, A., Whitley, R. and Kirmayer, J. L., 2012. Cultural contexts and constructions of recovery. In: A. Rudnick, ed*. Recovery of People with mental illness. Philosophical and related perspectives*. Oxford: Oxford University Press, pp.109-132.

Alderson, P., 1998. The importance of theories in health care. *British Medical Journal*, 317(7164), pp.1007-1010.

Amy, L., 2017. Komunizmi ka lene trauma te thella per shoqerine Shqiptare [Communism caused significant trauma to Albanians] [Online]. Tema, 18 September. Available from: http://www.gazetatema.net/2017/09/18/intervista-lori-amy-komunizmi-ka-lene-trauma-te-thelle-ne-shogerine-shqiptare-ja-cme-tha-withers-per-shqiptaret/ [Accessed December 12 2017].

Anderson, A. and West, S.G., 2011. Violence Against Health Professionals: When the Treater Becomes the Victim. *Innovations in Clinical Neuroscience,* 8(3), pp.34-39.

Angelova-Mladenova, L., 2017. *The Right to Live Independently and be Included in the Community: Addressing Barriers to Independent Living across the Globe.* European Network on Independent Living.

Archer, M., 1995. *Realist Social Theory: The Morphogenetic Approach.* Cambridge: Cambridge University Press.

Armstrong, G., 1993. Like that Desmond Morris? In D. Hobbs and T. May, eds. *Interpreting the field – Accounts of ethnography*. Oxford: Oxford University Press, pp.3-44.

Balabanova, D. and McKee, M., 2002. Understanding Informal Payments for Health Care: The example of Bulgaria. *Health Policy,* 62(3), pp.243–273.

Bardhoshi, N., 2012. Family property in Albanian customary law. In A. Hemming, G. Kera and E. Pandelejmoni, eds. *Albania: Family, society and culture in the 20th century*. Berlin: Lit Verlang, pp.67-78.

Bassman, R., 2000. Agents, not objects: our fight to be. *Journal of Clinical Psychology,* 56(11), pp.1396-1411.

Beauchamp, T.L. and Childress, J.F., 2001. *Principles of Biomedical Ethics.* 4th ed. Oxford: Oxford University Press.

Bellah, R.N., Madsen, R., Sullivan, W.M., Swidler, A. and Tipton, S.M, 1985. *Habits of the Heart: Individualism and Commitment in American Life.* Berkeley: University of California Press.

Bennett, C. and Howlett, M., 1992. The lessons of learning: reconciling theories of policy learning and policy change. *Policy Sciences,* 25(3), pp.275-294.

Beran, J. and Zavazalova, H., 2000. Problem situations between health personnel and patients (results of an analysis of patient complaints). *Casopis Lekaru Ceskych,* 139(7), pp.216-218.

Berger, L.P. and Luckmann, L., 1966. The Social Construction of Reality. London: Penguin Books.

Berman, P., 1995. Health sector reform: making health development sustainable. *Health Policy,* 32(1-3), pp.13-28.

Bhaskar, R., 1975. *A realist theory of science.* Leeds: Leeds Books.

Boevink, W., 2017. *Planting a Tree: On Recovery, Empowerment and Experiential Experience.* Utrecht: Trimbos Institute, Department of Reintegration.

Bonilla-Chacin, M.E., 2003. *Health and poverty in Albania: Background paper for the Albania poverty assessment.* Washington DC: World Bank.

Boylan, M., 2014. *Natural Human Rights: A theory.* New York: Cambridge University Press.

Brahimaj, F., 2017. Kreu i Urdhrit te Mjekeve, Fatmir Brahimaj: Imediate profilaksia e dhunes ndaj mjekeve [Physician protection is an immediate necessity] [Online]. *Doktor 33*. Tirane: Doktor 33. Available from: http://www.doktor33.al/cont/news/lajm/31496/kreu-urdhrit-mjekeve-fatmir-brahimaj-imediate-profilaksia.aspx#.WiSVmUqnGM8 [Accessed 2 December 2017].

Bredenkamp, C., Mendola, M. and Gragnolati, M., 2011. Catastrophic and impoverishing effects of health expenditure: new evidence from the Western Balkans. *Health Policy Plan,* 26(4), pp.349–356.

Brody, B., 1992. Special ethical issues in the management of PVS patients. *Journal of Law, Medicine & Health* Care, 20(1-2), pp.104-115.

Bryman, A. and Burgess, R., ed., 1994. *Analysing qualitative data.* London: Routledge.

Bryman, A., 2012. *Social Research Methods.* 4th ed. Oxford: Oxford University Press.

Cain, A., 2007. Reports Links Corruption to Poverty. *Internal Auditor,* 64(6), pp.18-20.

Cairns, R., Richardson, G. and Hotopf, M., 2010. Deprivation of Liberty: Mental Capacity Act safeguards versus the Mental Health Act. *The Psychiatrist*, 34(6), pp.246-247.

Canadian Mental Health Association, 2015. *What Next: Peer Support Program* [Online]. Toronto: Canadian Mental Health Association. Available from: https://toronto.cmha.ca/programs_services/what-next-peer-support-program/ [Accessed 2 January 2016].

Carta, M.G., 2014. Protection of People with Mental Disorders Human Rights: the Italian Perspective. *Implementing the WHO QualityRights Project in the Mediterranean Area,* 18-20 November 2014 Cagliari. Cagliari: The University of Cagliari and World Health Organization, pp.21-38.

Carta, M.G., 2016. Protection of People with Mental Disorders Human Rights. *The International Summer School.* 12-15 August 2016 Cagliari. Cagliari: The University of Cagliari and World Health Organization, pp.1-11.

Carter, I., Hanes, R. and MacDonald, J., 2017. Beyond the Social Model of Disability. In: D. Baines, ed. *Doing Anti-Oppressive Practice, Social Justice Social Work.* Winnipeg: Fernwood Publishing.

Centre for Addiction and Mental Health, 2017. *Your Rights* [Online]. Toronto: Bell. Available from: https://www.camh.ca/en/your-care/your-rights [Accessed 6 February 2017].

Centre for Addiction and Mental Health and Bell, 2016. *Let's Talk* [Online]. Toronto: Bell. Available from: https://letstalk.bell.ca/en/news/82/camh-and-bell-lets-talk-launch-new-online-mental-health-gateway-and-app-improving-access-to-care [Accessed May 12 2015].

Chamberlin, J., 1978. *On our own: Patient controlled alternatives to the mental health system.* New York: McGraw-Hill.

Chamberlin, J., 1995. Rehabilitating ourselves: The psychiatric survivor movement. *International Journal of Mental Health,* 24(1), pp.39-46.

Chawla, M., Berman, P. and Kawiorska, D., 1998. Financing health services in Poland: New evidence on private expenditures. *Health Economics,* 7(4), pp.337-346.

Choices, 2014. *Swedish Personal Ombudsman service for people with mental health problems* [Online]. Stockholm: Choices. Available from: http://www.right-to-decide.eu/2014/08/swedish-personal-ombudsman-service-po-for-people-with-mental-health-problems/ [Accessed 29 October 2015].

Circles Network, 1994. *Circles of Support* [Online]. Warwickshire: Circles Network. Available from: http://www.circlesnetwork.org.uk/ [Accessed 29 December 2015].

Civil Rights Defenders, 2015. *Country Report: Human Rights in Albania* [Online]. Stockholm: The Civil Rights Defenders. Available from: http://www.civilrightsdefenders.org/country-reports/human-rights-in-albania/ [Accessed 29 October 2015].

Cohen, J. and Ezer, T., 2013. Human Rights in patient care: A theoretical and practical framework. *Health and Human Rights Journal*, 15(2), pp.7-19.

Como, A., 2015. Mental Health Services in Albania and in the countries around – comparative reflections on the Workforce. *Albanian Medical Journal,* 4, pp.35-40.

Conrad. P. and Barker, K.K., 2010. The Social Construction of Illness: Key Insights and Policy Implications. *Journal of Health and Social Behavior,* 51(1), pp.67–79.

Corrigan, P.W. and Watson, A.C., 2002. Understanding the impact of stigma on people with mental illness. *World Psychiatry,* 1(1), pp.16-20.

Corrigan, P.W., Thompson, V., Lambert, D., Sangster, Y., Jeffrey, G.N. and Campbell, J., 2003. Perceptions of discrimination among persons with serious mental illness. *Psychiatric Services,* 54(8), pp.1105-1110.

Council of Europe, 2016. *Report to the Albanian Government on the Visit to Albania carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment of Punishment from February 4 to 14, 2014.* Strasburg: CPT/Inf (2016).

Creswell, J.W., 1994. *Research Design: Qualitative and Quantitative Approaches.* Thousand Oaks: SAGE Publications.

Creswell, J.W., 2014. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches.* Thousand Oaks: SAGE Publications.

Cullen-Drill, M. and Schilling, K., 2008. The case for mandatory outpatient treatment. *Journal of Psychosocial Nursing and Mental Health Services,* 46(2), pp.33-41.

Currie, J., 2012. *Assessment of the Mental Health Ward, Hargeisa Group Hospital in Somalia, Using the WHO Quality Rights Tool Kit* [Online]. Geneva: WHO. Available from: http://www.who.int/mental_health/policy/quality_rights/Somalia_qrs_report.pdf [Accessed 25 February 2016].

Dalky, H.F., 2012. Perception and coping with stigma of mental illness: Arab families' perspectives. *Issues in Mental Health Nursing,* 33(7), pp.486-491.

Danziger, D. and Gillingham, J., 2004. *1215: The Year of Magna Carta.* London: Hodder and Stoughton.

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D. and Tebes, J.K., 1999. Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice,* 6(2), pp.165 – 187.

de Leon, P. and de Leon, L., 2002. What Ever Happened to Policy Implementation? An Alternative Approach. *Journal of Public Administration Research and Theory*, 12(4), pp.467-492.

Demi, N. and Voko, K., 2014. *Report on the Survey of the Mental Health System in Albania.* Tirane: Ministria e Shendetesise se Shqiperise and World Health Organization, Albania.

Denzin, N. and Lincoln, Y., eds., 2000. *Handbook of Qualitative Research.* London: Sage Publications.

Desjarlais, R., Eisenberg, L., Good, B. and Kleinman, A., 1995. *World Mental Health. Problems and Priorities in Low Income Countries.* Oxford: Oxford University Press.

Dietrich, A.J., Oxman, T.E., Williams, J.W., Schulberg, H.C., Bruce, M.L., Lee, P.W., Barry, S., Raue, P.J., Lefever, J.J., Heo, M., Rost, K., Kroenke, K., Gerrity, M. and Nutting, P.A., 2004. Re-engineering systems for the treatment of depression in primary care: Cluster randomized controlled trial. *British Medical Journal*, 329(7466), pp.602–605.

Doll, B., 2003. The relationship between the clan system and other institutions in the Northern Albania. *Southeast European and Black Seas Studies*, 3(2), pp.147-162.

Donnelly, J., 1982. Human Rights and Human Dignity: An Analytic Critique of Non-Western Conception of Human Rights. *The American Political Science Review,* 76(2), pp.303-316.

Donnelly, J., 2011. The social construction of international human rights*. Relaciones Internacionales,* 17, pp.1-30.

Dudley, M., Silove, D.M. and Gale, F., 2012. Mental health, human rights and relationship: an introduction. In: M. Dudley, D. Silove, and F. Gale, eds*. Human Rights and Mental Health: Vision, Praxis and Courage.* Oxford: Oxford University Press, pp.1-49.

Drew, N., Funk, M., Tang, S., Lamichhane, J., Chávez, E., Katontoka, S., Pathare, S., Lewis, O., Gostin, L. and Saraceno, B., 2011. Human Rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. *The Lancet,* 378(9803), pp.1664-1675.

Drew, N., (Drewn@who.int), and Funk, M., (Funkm@who.int), 15 January 2016. *The Rights of People with Mental Disorders.* Email to L.Loli-Dano (L.Loli-Dano@camh.ca).

Dyrmishi, E., 2010. *Emigrimi shqiptar në konteksin e politikave ndërkombetare [Albanian immigration in the context of international politics]* [Online]. Tirane, AL: Ministria e Punes, Ceshtjeve Sociale dhe Shanseve te Barabarta. Available from: http://www.migrantservicecentres.org/userfile/Albania_al.pdf [Accessed 28 October 2015].

Economopoulos, N., 1991a. *Elbasan Psychiatric Hospital in 1991*. Magnum Photos. Available from: http://pro.magnumphotos.com/C.aspx?VP3=SearchResult&VBID=2K1HZO4UJ6BA5H&SMLS=1&RW=2000&RH=979 [Accessed 4 September 2017].

Economopoulos, N., 1991b. *Elbasan Psychiatric Hospital in 1991*. Magnum Photos. Available from:

http://pro.magnumphotos.com/C.aspx?VP3=SearchResult&VBID=2K1HZO4UMGM9IV&SMLS=1&RW=2000&RH=979 [Accessed 4 September 2017].

Economopoulos, N., 1991c. *Elbasan Psychiatric Hospital in 1991*. Magnum Photos. Available from: http://pro.magnumphotos.com/C.aspx?VP3=SearchResult&VBID=2K1HZO4UMGM9IV&SMLS=1&RW=2000&RH=979 [Accessed 4 September 2017].
Economopoulos, N., 1991d. *Elbasan Psychiatric Hospital in 1991*. Magnum Photos. Available from: http://pro.magnumphotos.com/C.aspx?VP3=SearchResult&VBID=2K1HZO4UMGM9IV&SMLS=1&RW=2000&RH=979 [Accessed 4 September 2017].

Economopoulos, N., 1991e. *Elbasan Psychiatric Hospital in 1991*. Magnum Photos. Available from: http://pro.magnumphotos.com/C.aspx?VP3=SearchResult&VBID=2K1HZO4UMGM9IV&SMLS=1&RW=2000&RH=979 [Accessed 4 September 2017].

Elder-Vass, D., 2012.*The Reality of Social Construction*. Cambridge: Cambridge University Press.

Epstein, R., 1998. *Principles for a free society. Reconciling Individual Liberty with the Common Good.* Cambridge: Perseus Publishing.

European Union, 2018. *Albania on its European Path.* Available from: https://ec.europa.eu/neighbourhood-enlargement/sites/near/files/near_factograph_albania.pdf [Accessed: November 8, 2018].

Farmer, P., 2003. *Pathologies of Power: Health, Human Rights, and the New War on the Poor.* Berkley: University of California Press.

Fawzy, M.E., 2015. Quality of life and human rights conditions in a public psychiatric hospital in Cairo. *International Journal of Human Rights in Healthcare*, 8(4), pp. 199–217. Available from: http://www.emeraldinsight.com/doi/pdfplus/10.1108/IJHRH-02-2015-0006 [Accessed 21 October 2016].

Fax.al, 2015. Korrupsioni, Arrestohen 4 Punonjes te Spitalit Psikiatrik ne Vlore [Corruption, 4 staff from the Vlora Psychiatric Hospital are Arrested] [Online]. *Fax.al* 10 June, Available from: http://fax.al/read/news/410532/9753033/korrupsioni-arrestohen-4-punonjes-te-spitalit-psikiatrik-ne-vlore [Accessed 3 November 2017].

Fielding, N.G. and Fielding, J.L., 1986. *Qualitative Research Methods Series 4.* Newbury Park: Sage Publications.

Finkelstein, V., 1988. To Deny or Not to Deny Disability. *Physiotherapy,* 74(12), pp.650-652. DOI: 10.1016/S0031-9406(10)62916-1.

Fleischer, D., 2001. *The Disability Rights Movement.* Philadelphia: Temple University Press.

Fletcher, J.C., 1992. Ethics committees on due process. *Law, Medicine and Health Care,* 20(4), pp.291-293.

Forzley, M., 2007. Improving transparency in the pharmaceutical sector: Report on the study to identify and strengthen decision points against corruption. *Albania Development Policy* P099823-DPL II. Tirana: Forzley & Associates.

Fullan, M., 2007. *The new meaning of educational change*. New York: Teacher's College Press.

Funk, N., Drew, N. and Saraceno, B., 2007. Global perspective on mental health policy and service development issues: WHO angle. In: M. Knap, D. McDaid, E. Mossialos, and G. Thornicroft, eds*. Mental Health Policy and Practice Across Europe. The future direction of mental health.* Berkshire: Open University Press, pp.424-440.

Funk, M., Drew, N., Freeman, M. and Faydi, E., 2010. *Mental Health and Development: targeting people with mental health conditions as a vulnerable group* [Online]. Geneva: World Health Organization. Available from: <http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf> [Accessed 1 November 2014].

Funk, M., (funkm@who.int), 1 July 2016. *New UN Resolution on Mental Health and Human Rights.* Email to L.Loli-Dano (laura@edlanet.com).

Gable, L. and Gostin, L.O., 2009. Mental Health as a Human Right. *Wayne State University Law School Legal Studies Research Paper Series No. 09-15.* Available from: http://www.ssrn.com/link/Wayne-State-U-LEG.html [Accessed 1 November 2014].

Gable, L. and Meier, B.M., 2013. Global health risks: Employing human rights to develop and implement the Framework Convention on Global Health. *Health and Human Rights Journal,* 15(1), pp.17-31.

Gazeta Tema, 2015. Drejtori i Arrestuar per Skandalin e Ilaceve i dha Dokumentin e Psikiatrise Konstandin Xhuvanit [The Arrested Director due to Medication scandal, provided Konstandin Xhuvani with Letter from the Psychiatry Hospital] *Tema* 6 June [Online]. Available from: http://www.gazetatema.net/2015/06/06/drejtori-i-arrestuar-per-skandalin-e-ilaceve-i-dha-dokumentin-e-psikiatrise-konstandin-xhuvanit/ [Accessed 6 June 2015].

Geertz, C., 1973. *The interpretation of Cultures.* New York: Basic Books.

Glaser, B.G., 2007. *Doing formal grounded theory: A proposal*. Mill Valley: Sociology Press.

Glickman, S.W., McHutchison, J.G., Peterson, E.D., Cairns, C.B., Harrington, R.A. and Califf, R.M., 2009. Ethical and scientific implications of the globalization of clinical research. *New England Journal of Medicine,* 360(8), pp.816-823.

Goffin, T., Borry, P., Dierickx. and Nys, H., 2008. Why eight EU Member States signed, but not yet ratified the Convention for Human Rights and Biomedicine. *Health Policy,* 86(2-3), pp.222-233.

Goffman, E., 1963. *Stigma.* London: Penguin.

Gregg, B., 2011. *Human Rights as Social Construction.* Cambridge: Cambridge University Press.

Green, J. and Thorogood, N., 2014. *Qualitative Methods in Health Research*. 3rd ed. London: SAGE Publications.

Greener, I., 2002. Understanding NHS reform: the policy-transfer, social learning and path-dependency perspectives. *Governance,* 15(2), pp.161-183.

Grigaitė, U., 2017. *Human Rights Conditions and Quality of Care in 'Independent Living Homes' for Adults, who have Intellectual and/or Psychosocial Disabilities, in Vilnius: Analysis of Good Practice Examples, Systemic Challenges and Recommendations for the Future.* Geneva: World Health Organization. [Online]. Available from: http://www.who.int/mental_health/policy/quality_rights/QRs_Lithuania.pdf?ua=1 [Accessed 2 May 2016].

Gorski, P., 2008. The myth of the culture of poverty. *Educational Leadership, 65*(7), pp.32-37.

Gorski, P., 2013. Complicating white privilege: Poverty, class, and knapsack. In S. Grineski, J. Landsman, and R. Simmons, eds. *Talking About Race: Alleviating the Fear*. Sterling, VA: Stylus.

Guba, E.G. and Lincoln, Y.S., 1994. Competing paradigms in qualitative research. In: N.K. Denzin and Y.S. Lincoln, ed. *Handbook of qualitative research.* Newbury Park: SAGE Publications, pp.105-117.

Guest, G., Arwen, B. and Johnson, L., 2006. How many interviews are enough: An experiment with data saturation and variability. *Field Methods,* 18(1), pp.59-82. DOI: 10.1177/1525822X05279903.

Hafner-Burton, E.M. and Tsutsui, K., 2005*. Replication data for: Human Rights Practices in a globalizing world: The paradox of empty promises* [Online]*.* Available from: http://hdl.handle.net/1902.1/10487UNF:3:EMcZWT0FrM1S+Zv8GzR1ng==EmilieM. Hafner-Burton [Distributor] V1 [Version] [Accessed May 12 2015].

Hajdini, G., 2009. *Health in Albania. National Background Report* [Online]. Tirane: Ministry of Health of Albania. Available from: https://www.academia.edu/1795327/Health_in_Albania_A_National_Background_Report [Accessed 12 November 2015].

Hammersley, M. and Atkinson, P., 2007. *Ethnography: Principles in Practice.* 3rd ed. London: Routledge.

Hardison, W.G., 1996. I've been where it's gone, so I know what I got ... An American Fullbright lecturer in Albania. *American College of Physicians,* 125(10), pp.835-838.

Harris, I., 2012. Edmund Burke. In: E.N. Zalta, ed. *The Stanford Encyclopedia of Philosophy* [Online]. Standford: Stanford University. Available from: https://plato.stanford.edu/archives/spr2012/entries/burke/ [Accessed 5 June 2016].

Hathaway, O.A., 2002. *Do Human Rights Treaties Make a Difference?* Faculty Scholarship Series. Paper 839. Available from: http://digitalcommons.law.yale.edu/fss_papers/839/ [Accessed 12 November 2015].

Healy, M. and Perry, C., 2000. Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Market Research*, 3(3), pp.118-126.

Heard, A., 1997. *Human Rights: Chimeras in Sheep's Clothing?* [Online]. Burnaby: Simon Fraser University. Available from: https://www.sfu.ca/~aheard/intro.html [Accessed 3 March 2015].

Hekkert, K.D., Cihangir, S., Kleefstra, S.M., van den Berg, B. and Kool, R.B., 2009. Patient satisfaction revisited: A multilevel approach. *Social Science and Medicine,* 69(1), pp.68-75.

Helman, C.G., 2000. *Culture, health, and illness.* 4th ed. London: Butterworth-Heinemman.

Henderson, C., Evans-Lacko, S. and Thornicroft, G., 2013. Mental Illness Stigma, Help Seeking, and Public Health Programs. *American Journal of Public Health,* 103(5), pp.777-780. DOI: 10.2105/AJPH.2012.301056.

Henry, T.G., 1990. *Practical Sampling.* Newbury Park: Sage Publications.

Hoshmand, I.S.T., 1989. Alternate Research Paradigms: A review and teaching proposal. The *Counseling Psychologist*, 17(1), pp.3-79.

Hojjatoleslami, S. and Ghodsi, Z., 2010. Respect the rights of patient in terms of hospitalized clients: a cross-sectional survey in Iran, 2010. *Procedia – Social and Behavioural Sciences,* 31(0), pp.464-467.
DOI: http://dx.doi.org/10.1016/j.sbspro.2011.12.087.

Holton, J.A., 2010. The coding process and its challenges. *The Grounded Theory Review,* 9(1), pp.21-40.

Hopper, K., Jost, J. and Hay, T., 1997. Homelessness, severe mental illness, and the institutional circuit. *Psychiatric Services,* 48(5), pp.659-665.

Hotchkiss, D. R., Hutchinson, P.L., Altin, M. and A.A. Berruti., 2004. *Out-of-pocket payments and utilization of health care services in Albania: Evidence from 3 districts.* Bethesda: Partners for Health Reformplus Project, Abt Associates, Inc.

Huntington, S.P., 1996. *The West: Unique, Not Universal. Foreign Affairs,* 75(6) [Online]. Available from: https://www.foreignaffairs.com/articles/1996-11-01/west-unique-not-universal [Accessed 3 December 2017].

Hutchins, R., 1996. *Historical dictionary of Albania.* Lanham: The Scarecrow Press, Inc.

Institute of Public Health, 2014. *National Health Report. Health Status of the Albania Population* [Online]. Tirane: Institute of Public Health. Available from: http://ishp.gov.al/wp-content/uploads/2015/04/Health-report-English-version.pdf [Accessed 13 November 2016].

Institute of Statistics (INSTAT), 2016. *Wages 2016* [Online]. Tirane: INSTAT. Available from: http://www.instat.gov.al/en/themes/labour-market-and-education/wages/ [Accessed 12 November 2017].

Instituti i Statistikes (INSTAT), 2018. *Popullesia e Shqiperise* [*Population of Albania, 2018* [Online]. Tirane: INSTAT. Available from: http://www.instat.gov.al/al/temat/treguesit-demografik%C3%AB-dhe-social%C3%AB/popullsia/publikimet/2018/popullsia-e-shqip%C3%ABris%C3%AB-1-janar-2018/ [Accessed 3 February 2018].

Ivankova, N.V., Creswell, J.W. and Stick, S.L., 2006. Using mixed-methods sequential explanatory design: from theory to practice. *Field Methods,* 18(1), pp.3-20.

Jacob, K., 2001. Community care for people with mental disorders in developing countries: Problems and possible solutions. *The British Journal of Psychiatry,* 178(4), pp.296-298.

Jacobs, R., Gutacker, N., Mason, A., Goddard, M., Gravelle, H., Kendrick, T. and Gilbody, S., 2015. Determinants of hospital length of stay for people with serious mental illness in England and implications for payment systems: a regression analysis. *BMC Health Services Research.* 15(1), pp.439-455. DOI 10.1186/s12913-015-1107-6.

Jick, T.D., 1979. Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly,* 24(4), pp.602-611.

Johnson, F., 1985. The Western Concept of Self. In: Marsella, A.J., Devos, G. and Hsu, F.I.K., ed. *Culture and Self: Asian and Western Perspectives*. New York: Tavistock Publications, pp.91-138.

Johnson, R.B., Onwuegbuzie, A.J. and Turner, L.A., 2007. Toward a Definition of Mixed Methods Research. *Journal of Mixed Methods Research*, 1(2), pp.112-133.

Kaser, K., 2000. The history of the family in Albania in the 20th century. A first profile. *Ethnologia Balkanica,* 4, pp.45-57.

Kenny, C., 2009. The effect of Corruption in Infrastructure: Evidence from Transition and Developing Countries. *Journal of Development Studies*, 45(3), pp. 314-332.

Killaspy, H., King, M., Wright, C., White, S., McCrone, P., Kallert, T., Cervilla, J., Raboch, J., Onchev, G., Mezzina, R., Wiersma, D., Kiejna, A., Ploumpidis, D., Caldas, A. and Jose, M., 2009. Study protocol for the development of a European measure of best practice for people with long term mental health problems in institutional care. *BioMed Central Psychiatry Journal,* 9(36), pp.36-44.

Kitayama, S. and Park, H., 2007. Cultural shaping of self, emotion, and well-being: how does it work? *Social and Personality Psychology Compass,* 1, pp.202-222. DOI: 10.1111/j.1751-9004.2007.00016.x.

Kleinman, A., 2009. Global mental health: a failure of humanity. *Lancet,* 374(9690), pp. 603-604.

Knapp, M., McDaid, D., Mossialos, E. and Thornicroft, G., 2007. European Observatory on Health Systems and Policies Series. Mental health policy and practice across Europe: an overview. In: M. Knapp, D. McDaid, E. Mossialos and G. Thornicroft, ed. *Mental health policy and practice across Europe. The future direction of mental health care.* Berkshire: Open University Press, pp.1-15.

Knapp, M. and McDaid, D., 2007. Financing and funding mental health care services. In: M. Knapp, D. McDaid, E. Mossialos and G. Thornicroft, ed. *European Observatory on Health Systems and Policies Series. Mental health policy and practice across Europe. The future direction of mental health care.* Berkshire: Open University Press, pp.60-99.

Kohn, R., Saxena, S., Levav, I. and Saraceno, B., 2003. The treatment gap in mental health care. *Bulletin of the World Health Organization,* 82(11), pp.858-66.

Kryeministria, 2014. *Shqiperia, Kandidat ne BE* [Albania, an EU candidate country] [Online]. Tirane: Kryeministria. Available from: http://www.kryeministria.al/al/newsroom/lajme/shqiperia-kandidat-ne-be [Accessed 4 January 2016].

Kuvendi Popullor, 2003. *Kushtetuta e Republikes se Shqiperise* [The Constitution of the Republic of Albania] [Online]. Tirane: Kuvendi Popullor. Available from: http://www.klsh.org.al/web/pub/20071109103905_kushtetuta_e_republikes_se_shqiperise_28_1.pdf [Accessed 4 January 2016].

Ladefoged, J., 1997. *The Albanians.* Manville: VII Photo. Available from: http://viiphoto.com/vii-stories/the-albanians-by-joachim-ladefoged/ [Accessed 4 September 2017].

Lamcja, A., (adela.lamcja@live.com), 23 February 2016. *An Overview of Inpatient Psychiatric Services.* Email to L.Loli-Dano (laura@edlanet.com).

Lavagnoli, S., 2011. *UN Office of the High Commissioner for Human Rights - CRPD: Key legislative measures for its effective implementation. Available from:* http://www.unescap.org/sdd/issues/disability/crpd/files/Paper-I-OHCHR-20110121.pdf [Accessed June 1 2016].

Lincoln, S.Y. and Guba, G.E., 1985. *Naturalistic Enquiry.* London: Sage Publications.

Lewis, M., 2000. Who is Paying for Health Care in Eastern Europe and Central Asia? *Human Development Sector Unit, Europe and Central Asia Region.* Washington DC: World Bank.

Lika, B., 2013. Informal Payments in the Public Health Service of Elbasan, Albania. *The Beagle: A Journal of Student Research and Enterprise* [Online]. Available from: https://journals.gre.ac.uk/index.php/beagle/article/view/103 [Accessed 3 December 2016].

Lund, C. and Fisher A.J., 2003. Community hospital indicators in South African public sector mental health services. *Journal of Mental Health Policy and Economics,* 6(4), pp.181- 187.

Luhrmann, T.M., 2007. Social Defeat and the culture of chronicity; or, why Schizophrenia does so well over there and so badly here. *Culture, Medicine and Psychiatry,* 31(2), pp.135-172.

Markowitz, F.E., 2004a. Sociological Models of Mental Illness Stigma: Progress and Prospects. In P.W. Corrigan, ed. *On the Stigma of Mental Illness: Implications for Research and Social Change.* Washington DC: American Psychological Association, pp.129-144.

Marku, M., 2010. Preliminary Analysis of Albanian Health System Financing and Corruption. *Project Against Corruption in Albania* [Online]. Tirane: Council of Europe. Available from: https://rm.coe.int/16806ec8be [Accessed 2 September 2015].

Matland, R.E., 1995. Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation. *Journal of Public Administration Research and Theory*, 5(2), pp.145-174.

Maykut, P. and Morehouse, R., 1994. *Beginning qualitative research: A philosophic and practical guide*. Philadelphia: Falmer Press.

Mays, N. and Pope, C., 1995. Qualitative Research: Observational methods in health care settings. *British Medical Journal,* 311(6997), pp.182-188.

Mazmanian, D. and Sabatier, P., 1983. *Implementation and Public Policy*. Glenview III: Scott, Foresman.

Mensch, J.R., 2010. *A Theory of Human Rights:* open Democracy [Online]. Available from: <https://www.opendemocracy.net/james-r-mensch/theory-of-human-rights> [Accessed 10 January 2015].

Mental Health Commission, 2014. Featured Symposium – Mental Health Commissions: Expectations and Realities. What we share makes us strong – *The MHS Conference,* 27-29 August 2014, Perth. Perth: The MHS [Online]. Available from: http://www.themhs.org/blog/135/themhs-2014-s082-featured-symposium-mental-health-commissions-expectations-and-realities-hh [Accessed 4 January 2016].

Menzies, I.E.P., 1992. *Containing Anxiety in Institutions. Selected Essays.* London: Free Association Books.

Migrants at Sea, 2011. 20th Anniversary of the Arrival at Bari, Italy of 15,000 Albanian Boat People [Online]. LA: Migrants at Sea. Available from: https://migrantsatsea.org/2011/07/29/20th-anniversary-of-the-arrival-at-bari-italy-of-15000-albanian-boat-people/ > [Accessed 3 December 2017].

Miles, B.M. and Huberman, M.A., 1994. *An expanded sourcebook: Qualitative Data Analysis*. Thousand Oaks: SAGE Publications.

Ministry of Health of Albania, 2003. *The Policy and the Operational Plan for Mental Health Services Development in Albania* [Online]. Tirane: Ministry of Health of Albania. Available from: http://www.shendetesia.gov.al/files/userfiles/Baza_Ligjore/Dokumenta_strategjike/5.pdf [Accessed 28 October 2015].

Ministria e Shendetesise e Shqiperise, 2009. *Plani i Integruar i Shqiperise 2010.* [The 2010 Integrated Plan of Albania] [Online]. Tirane: Ministria e Shendetesise e Shqiperise. Available from: http://www.shendetesia.gov.al/files/userfiles/Baza_Ligjore/Dokumenta_strategjike/8.pdf [Accessed 4 January 2016].

Ministry of Health of Albania, 2009. *Albania HIS Work Plan: 2010-2015* [Online]. Tirane: Ministry of Health of Albania. Available from: http://www.who.int/healthmetrics/library/countries/HMN_ALB_StrPlan_Final_2009_12_en.pdf [Accessed 4 January 2016].

Ministria e Shendetesise e Shqiperise, 2013. *Plani i Veprimit per Zhvillimin e Sherbimeve te Shendetit Mendor 2013-2022* [Action Plan of Mental Health Services Developments in Albania 2013-2022] [Online]. Tirane: Ministria e Shendetesise e Shqiperise. Available from: <http://www.shendetesia.gov.al/files/userfiles/Baza_Ligjore/Dokumenta_strategjike/pv1.pdf> [Accessed 27 September 2015].

Ministry of Foreign Affairs of Albania, 2015. *Albania and the United Nations, 60 Years Partnership* [Online]. Tirane: Ministry of Foreign Affairs. Available from: http://www.punetejashtme.gov.al/files/userfiles/press_brochure_minfor_(2).pdf [Accessed 12 March 2018].

Monahan, J., Swartz, M. and Bonnie, R.J., 2003. Mandated treatment in the community for people with mental disorders. *Health Affairs,* 22(5), pp.28-38.

Monahan, J., Steadman, H., Robbins, P., Appelbaum, P., Banks, S., Grisso, T., Heilbrun, K., Mulvey, E., Roth, L. and Silver, E., 2005. An actuarial model of violence risk assessment for persons with mental disorders. *Psychiatric Services,* 56(7), pp.810-815.

Moreno, P.M., 2010. *Evaluation of Mental Health Services – Principality of Asturias* [Online]. Geneva: World Health Organization Available from: http://www.who.int/mental_health/policy/quality_rights/Asturias_qrs_ENG.pdf?ua=1 [Accessed 2 May 2016].

Morse, J.M., 1991. Approaches to qualitative – quantitative methodological triangulation. *Nursing Research,* 40(1), pp.120-123.

Muca, 2012. Arjan Laska Qellohet per Vdekje nga nje 25 Vjecar. Drejtori: Kam Marre Masa Ndaj Personelit. [Arjan Laska is Seriously injured from a 25 year Old Person. The Director: Punitive Measures are Taken Against Staff] [Online]. *Gazeta Shqip*, 17 October 2012. Available from: http://gazeta-shqip.com/lajme/2012/10/17/zenke-mes-pacienteve-ne-spitalin-psikiatrik-ne-elbasan-nje-i-vdekur/ [Accessed: 18 October 2016].

Mueller, R.L., 2013. Deinstitutionalization and Social Inclusion in Albania. *Academia* [Online]. Available from: http://www.academia.edu/5184939/Deinstitutionalization_and_Social_Inclusion_in_Albania [Accessed 28 October 2015].

Mueller, R.L., 2014. Global Mental Health: The View from Albania. *Annals of Global Health.* 80(3), pp.232. DOI: http://dx.doi.org/10.1016/j.aogh.2014.08.187Q.

Murdie, A., 2009. The Impact of Human Rights NGO Activity on Human Rights Practices. *International NGO Journal,* 4(10), pp.421-440.

Muzeu i Memories, 2014. *Albania in Communism.* Tirane: Muzeu i Memories. Available from: http://muzeuimemories.info [Accessed June 1 2016].

Muzeu i Memories, 2014a. *Collapse of "Hoxha" Monument Marking the Collapse of Communism in February 1991.* Tirane: Muzeu i Memories. Available from: http://muzeuimemories.info/en/ [Accessed 6 September 2017].

National Museum of Albania, 2017. *Political Victims of Communism Sent for Psychiatric Treatment at the Elbasan Psychiatric Hospital until 1991.* Tirane: National Museum of Albania.

Nomidou, A., 2012. *Quality Health Care and Human Rights Conditions in a Psychiatric Clinic of a General Hospital* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/policy/quality_rights/Greece_qrs_report.pdf?ua=1 [Accessed: 3 May 2016].

Newman, W.L., 2000. *Social Research Methods: qualitative and quantitative approaches.* 4th ed. Boston: Allyn and Bacon.

Nuri, B. and Tragakes, E., 2002. Health care systems in transition: Albania. *European Observatory on Health Care Systems* [Online]. Copenhagen: World Health Organization. Available from: http://www.euro.who.int/__data/assets/pdf_file/0009/96426/E80089.pdf [Accessed 28 October 2015].

Oakes, P., 2015. WHO technical assistance to support the inter-ministerial working group on de-institutionalization of residents with intellectual disabilities in mental hospitals of Vlore and Elbasan. *Technical Report September – December 2015.* Tirane: World Health Organization.

O'Flaherty, M., 2002. *Human Rights and the UN: Practice Before the Treaty Bodies,* 2nd ed. The Hague: Kluwer International.

O'Hara, M., 2012. Fighting for their rights. *Mental Health Today* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/policy/quality_rights/mht_article_quality_rights.pdf> [Accessed 12 October 2015].

Oliver, M., 1996. *Understanding disability: from theory to practice.* Basingstoke: Macmillan.

Organisation for Economic Co-operation and Development, 2017. *Health at a Glance* [Online]. Paris: OECD. Available from: http://www.oecd.org/countries/albania/. [Accessed 12 February 2018].

Orr, D., 2013. Sally Hodkin murder: NHS mental health care is a 'Cinderella' service. *The Guardian* [Online]. March 9, 2013. Available from: https://www.theguardian.com/society/2013/mar/09/sally-hodkin-nhs-mental-health [Accessed 2 January 2016].

Ozdemir, H. M., Ergonen, T. A., Sonmez, E., Can, O. I. and Salacin, S., 2006. The approach taken by the physicians working at educational hospitals in Izmir towards patient rights. *Patient Education and Counselling,* 61(1), pp.87-91.

Parker, C., 2007. Developing mental health policy: a human rights perspective. In: M. Knapp, D. McDaid, E. Mossialos and G. Thornicroft, ed. *Mental health policy and practice across Europe. The future direction of mental health care.* Berkshire: Open University Press, pp. 308-336.

Parwiz, K., 2015. *Implementation of WHO Quality Rights assessment in Kabul Mental Health Hospital.* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/policy/quality_rights/QR_Afghanistan.pdf?ua=1 [Accessed 1 June 2016].

Patton, M.Q., 1990. *Qualitative evaluation and research methods. 2nd ed.* Newbury Park: Sage Publications.

Patton, M., 2002. *Qualitative research and evaluation methods.* 3rd ed. Thousand Oaks: SAGE Publications.

Pierson, P., 2000. Increasing returns, path dependence and the study of politics. *American Political Science Review,* 94(2), pp.251-267.

Pressman, J. and Wildavsky, A., 1984. *Implementation.* 3rd ed. Berkeley: University of California Press.

QSR International, 2011. *NVivo Software*. Melbourne: QSR International.

Rekhis, M., 2015. *Rights of People with Mental Disorders. Realities and Perceptions* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/policy/quality_rights/qr_tunisia.pdf [Accessed 2 January 2016].

Risjord, M., Moloney, M. and Dunbar, S., 2001. Methodological Triangulation in Nursing Research. *Philosophy of the Social Sciences,* 31(1), pp.40-59.

Ritsher, J. and Phelan, J., 2004. Internalized stigma predicts erosion of morale among psychiatric outpatients. *Psychiatry Research,* 129(3), pp.257-65.

Reid, W.H., 2008. Assaults against psychiatrists and other mental health professionals. *Journal of Psychiatric Practice.* 14(3), pp.179–181.

Robertson, D.M. and Walter, G., 2008. Many faces of the dual-role dilemma in psychiatric ethics. *Australian and New Zealand Journal of Psychiatry,* 42(3), pp.228-235.

Rose-Ackerman, S., 1999. *Corruption and government: Causes, consequences, and reform*. Cambridge: Cambridge University Press.

Roethlisberger, F.J. and Dickson, W.J., 1939. *Management and the worker.* Cambridge: Harvard University Press.

Rouse, J., 2008. Comparative Analysis. In: R. Thorpe and R. Holt, ed. *The SAGE Dictionary of Qualitative Management Research.* London: SAGE Publications, pp.45-47.

Roy, O. and Annicchino, P., 2014. Human Rights between Religion, Culture and Universality. In: A. Vrdoljak, ed. *The Cultural Dimension of Human Rights.* Oxford: Oxford University Press, pp.13-25.

Ruger, P.J., 2010. *Health and Social Justice.* Oxford: Oxford University Press.

Ryen, A., 2004. Ethical issues. In: C. Seale, G. Gobo, J.F. Gubrium and D. Silverman, eds. *Qualitative Research Practice.* London: Sage, pp.230–247.

Sabatier, P.A., 1999. *Theories of the policy process, ed.* Boulder: Westview Press.

Sabatier, P. and Jenkins-Smith, H., 1999. The advocacy coalition framework: an assessment. In P. Sabatier, ed. *Theories of the Policy Process.* Boulder: Westview Press, pp.117-168.

Saraceno, B. and Saxena, S., 2005. Mental Health Services in Central and Eastern Europe: current state and continuing concerns. *Epidemiologia e Psichiatria Sociale,* 14(2), pp.44-48.

Sawicka, I., 2013. A Crossroad between West, East and Orient – The Case of Albanian Culture. *Colloquia Humanistica,* 2, pp.97-113.
DOI: http://dx.doi.org/10.11649/ch.2013.006.

Saxena, S., Funk, M. and Chisholm, D., 2013. World Health Assembly adopts Comprehensive Mental Health Action Plan 2013–2020. *The Lancet,* 381(9882), pp.1970-1971.

Schmidt, F., 1998. Upheaval in Albania. *Current History,* 97, pp.127-131.

Schwandt, T.A., 2003. Three epistemological stances for qualitative inquiry: Interpretativism, hermeneutics and social constructionism. In N. Denzin and Y, Lincoln, ed. *The landscape of Qualitative Research: Theories and issues*. Thousand Oaks: Sage, pp.292-331.

Seale, C., 1999. Quality in qualitative research. *Qualitative Inquiry,* 5(4), pp.465-478.

Sen, A., 1979. Utilitarianism and Welfarism. *The Journal of Philosophy,* 76(9), pp. 463-489. DOI: 10.2307/2025934.

Swedish International Development Corporation Agency (SIDA), 2008. *Albania Anti-Corruption Study*. Copenhagen: SIDA. Available from: http://www.aidharmonisation.org.al/skedaret/1203101753-SIDA%20Albania%20Anti-Corruption%20Study%20-%20Revised.pdf [Accessed 2 January 2017].

Silverman, D., 1985. *Qualitative methodology and sociology: Describing the social world.* Aldershot: Gower.

Simons, H.L., ed., 1994. *Marx: Selected Writings 1818-1883.* Indiana: Hacket Publishing Company.

Skuqi, T., 2014. *Abuse with Hospital Funds Leading to Inhumane Living Conditions at the Ali Mihali Vlora Psychiatric Hospital*. Tirane: SHGD. Available from: http://investigim.al/en/zbardhen-abuzimet-ne-psikiatrine-e-vlores-pacientet-ne-kushte-skandaloze/ [Accessed 6 September 2017].

Slade, M., 2012. The epistemological basis of personal recovery. In: A. Rudnick, ed. *Recovery of People with Mental Illness: Philosophical and Related Perspectives.* Oxford: Oxford University Press, pp.78-94.

Sowers, W. and Marin, R., 2014. A community Engaged Curriculum for Public Service Psychiatry Fellowship Training. *Community Mental Health Journal,* 50(1), pp.17-24.

Sprenkle, D.H. and Moon, S.M., 1996. *Research methods in family therapy.* New York: Guilford Press.

Stein, M.A., 2007. Disability Human Rights. *California Law Review,* 95(75), pp.1-63.

Su, L., Huang, J., Yang, W., Shen, Y. and Xu, Y., 2012. Ethics, patient rights and staff attitudes in Shangai's psychiatric hospitals. *BMC Medical Ethics*, 13(8), DOI: 10.1186/1472-6939-13-8.

Suggett, D., 2011. The implementation challenge: strategy is only as good as its execution. *State Services Authority Occasional Paper,* SSA/ANZSOG Occasional Paper, 15. Melbourne: ANZSOG.

Suli, A., Lazëri, L. and Nano, L., 2004. Mental health services in Albania. *International Psychiatry,* 4, pp.14-15.

Syse, A., 2000. Norway: valid (as opposed to informed) consent. *Lancet,* 356(9238), pp.1347-8.

Tambuyzer, E., Pieters, G. and Van Audenhove, C., 2011. Patient involvement in mental health care: One size does not fit all. *Health Expectations,* 17(1), pp.138-150.

Tashakkori, A. and Teddlie, C., 1998. *Mixed Methodology: Combining qualitative and quantitative approaches.* Thousand Oaks: SAGE Publications.

The Assembly, 2008. *On protection of personal data: No. 9887* [Online]. Available from: *http://www.coe.int/t/dghl/standardsetting/dataprotection/National%20laws/ALBANIA_DPLaw2008.pdf* [Accessed 3 June 2016].

Theobald, R., Hutchcroft, P.D., Rose-Ackerman, S. and K.A. Elliot., 2002. Containing Corruption. *New Political Economy*, 7(3), pp.435-449.

The Organisation for Economic Co-operation and Development (OECD), 2017. Health at a Glance 2017 [Online]. Available from: https://www.oecd.org/els/health-systems/Health-at-a-Glance-2017-Chartset.pdf [Accessed 28 December 2017].

The People's Assembly, 1991. *Civil Code of Albania* [Online]. Tirane: The People's Assembly. Available from: http://www.wipo.int/edocs/lexdocs/laws/en/al/al064en.pdf [Accessed 28 October 2015].

The People's Assembly, 1996. *On Mental Health* [Online]. Tirane: The People's Assembly. Available from: file:///F:/Downloads/mental_health_act__no._8092__21-_03-_1996_%20(2).pdf [Accessed 30 October 2015].

Thornicroft, G. and Tansella, M., 1999. *The Mental Health Matrix: A Manual to Improve Services.* Cambridge: Cambridge University Press.

Thornicroft, G. and Tansella, M. 2004. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. *British Journal of Psychiatry*, 185(440), pp.283-90.

Thornicroft, G., Brohan, E., Rose, D., Sartorious, N. and Leese, M., 2009. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *The Lancet*, 373(9661), pp.408–415.

Together for Life, 2017. *Pacientet dhe Instituticionet Shendetesore Perballe ne nje Tryeze per Permiresimin e Sistemit* [Patients and Health Institutions along each other for improving the Health System] [Online]. Tirane: Together for Life. Available from: http://togetherforlife.org.al/home/sq/ [Accessed 3 November 2017].

Tomini, S.M., Packard, T.G. and Tomini, F., 2013. Catastrophic and impoverishing effects of out-of-pocket payments for health care in Albania: evidence from Albania living standards measurement surveys 2002, 2005 and 2008. *Health Policy Plan*, 28(4), pp.419–28.

Tomini, S.M., Groot, W., Pavlova, M. and Tomini, F., 2015. Paying Out-of-Pocket and Informally for Health Care in Albania: The Impoverishing Effect on Households. *Frontiers in Public Health, 3* [Online]. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4551817/#B2 [Accessed December 1 2016] DOI: 10.3389/fpubh.2015.00207.

Tomov, T., Van Voren, R., Keukens, R. and Puras, D., 2007. In: M. Knapp, D. McDaid, E. Mossialos, and G. Thornicroft, ed. *European Observatory on Health Systems and Policies Series. Mental health policy in former eastern bloc countries.* Berkshire: Open University Press, pp.397-426.

Transparency International, 2016. *Albania: Transparency International's Corruption Perception Index* [Online]. Berlin: Transparency International. Available from: https://www.transparency.org/country/ALB [Accessed 2 December 2017].

Trochim, W.M.K. and Donnelly, J.P., 2007. *Research methods knowledge base.* 3rd ed. Mason: Thomson Custom Publications.

Tuckness, A., 2016. Locke's Political Philosophy. In: E.N. Zalta, ed. *The Stanford Encyclopedia of Philosophy* [Online]. Available from: https://plato.stanford.edu/archives/spr2016/entries/locke-political/ [Accessed 5 June 2016].

United Kingdom Parliament: The National Archives, 1998. *The Data Protection Act 1998* [Online]. Available from: http://www.legislation.gov.uk/ukpga/1998/29/section/33 [Accessed 21 May 2016].

United Nations, 1948. *Universal Declaration of Human Rights* [Online]. New York: United Nations. Available from: <http://www.un.org/en/universal-declaration-human-rights/> [Accessed 21 December 2015].

United Nations, 1999. *UN Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms, Article 18, General Assembly* [Online]. New York: United Nations. Available from: https://www.un.org/ruleoflaw/blog/document/declaration-on-the-right-and-responsibility-of-individuals-groups-and-organs-of-society-to-promote-and-protect-universally-recognized-human-rights-and-fundamental-freedoms/ [Accessed June 1 2015].

United Nations, 2007. From exclusion to equality. Realizing the rights of persons with disabilities. *Handbook for Parliamentarians on the Convention on the Rights of Persons with Disabilities and its Optional Protocol.* New York: United Nations, Nr. 14-2007.

United Nations, 2014. Economic and Social Council. Committee on Economic, Social and Cultural Rights, Fifty-first session. *Summary record of the 33rd meeting*. Geneva: United Nations, (E/C.12/2013/SR.33).

United Nations, 2016. *Treaty Collection* [Online]. New York: United Nations. Available from: https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-9-b&chapter=4&lang=en [Accessed 12 January 2016].

United States Agency for International Development, 2013. *Health Care System in Albania, A Formative Research with Consumers to Increase Non-State Actors' Engagement in Health System Governance* [Online]. Bethesda: United Stated Agency for International Development. Available from: http://pdf.usaid.gov/pdf_docs/PA00JVRJ.pdf [Accessed 21 December 2015].

United States Department of State, 2014. *Country Reports on Human Rights Practices for 2014 Albania* [Online]. Washington: United States Department of State. Available from: https://www.state.gov/documents/organization/236704.pdf [Accessed 3 November 2017].

United States Department of State, 2017. *Country Reports on Human Rights Practices for 2016* Albania [Online]. Washington DC: United States Department of State. Available from: https://www.state.gov/documents/organization/236704.pdf [Accessed 3 November 2017].

University of Bath, 2014. *University of Bath Research Data Policy.* Available from: http://www.bath.ac.uk/research/data/policy/ [Accessed June 1 2015].

Valimaki, M., Kuosmanen, L., Karkkainen J. and Kjervik, K.D., 2009. Patients' rights to complain in Finish psychiatric care: An overview. *International Journal of Law and Psychiatry,* 32, pp.184-188. DOI: 10.1016/j.ijlp.2009.02002.

Van Meter, D. and Van Horn, C., 1975. The policy implementation process: a conceptual framework. *Administration and Society* 6(4), pp.445-488.

Verschoor, C.C., 2010. Fight Against Corruption Escalates. *Strategic Finance* 91(9), pp.13-61.

Vian, T., Gryboski, K., Hall, R. and Sinoimeri, Z., 2004. Informal Payments in the Public Health sector in Albania: Final Report. *Partners for Health Reform Plus Project.* Bethesca: Abt. Associates Inc.

Vian, T., Gryboski, K., Hall, R. and Sinoimeri, Z., 2006. Informal payments in government health facilities in Albania: Results of a qualitative study. *Social Science and Medicine,* 62, pp.877–887. Available from: https://pdfs.semanticscholar.org/5a54/71cf8b469463dc046d61a27aef76b484a127.pdf [Accessed 21 December 2015].

Vian, T., 2011. Project Against Corruption in Albania (PACA). *Technical Paper: Risk Assessment: Corruption in the Health Sector in Albania* [Online]. Brussels: Council of Europe. CMU-PACA-14/2011. Available from: http://www.bu.edu/actforhealth/Risk%20Assessment/Vian_2011_Risk_Assessment2_Albania.pdf [Accessed 21 December 2015].

Vigo, D., Thornicroft, G. and Atun, R., 2016. Estimating the true global burden of mental illness. *Lancet Psychiatry,* 3(2), pp.171–78.

Vyshka, G. and Kruja, V., 2011. Inapplicability of advance directives in a paternalistic setting: the case of a post-communist health system. *BMC Medical Ethics,* 12(12), pp.1-6.

Wagner, E.H., Austin, B.T. and VonKorff, M., 1996. Organizing care for patients with chronic illness. *Milbank Q,* 74(4), pp.511-44.

Wallace, S.L., 2013. A View of Health Care Around the World. *Ann Fam Med*, 11(1), pp.84-85.

Walker, M.T., 2006. The Social Construction of Mental Illness and its Implications for the Recovery Model. *International Journal of Psychosocial Rehabilitation,* 10(1), pp.71-87.

Walt, G., 1998. Implementing health care reform: a framework for discussion. In: R.B. Saltman, J. Figueras and C. Sakellarides, ed. *Challenges for Health Care Reform in Europe.* Buckingham: Open University Press, pp.365-84.

Waltz, S., 2002. Reclaiming and rebuilding the history of the Universal Declaration of Human Rights. *Third World Quarterly,* 23(3), pp.437-448.

Warren, C.A.B. and Karner, T.X., 2005. *Discovering Qualitative methods: Field Research, Interviews and Analysis.* Los Angeles: Roxbury.

Watchirs, H., 2005. Human rights audit of mental health legislation – results of an Australian pilot. *International Journal of Law and Psychiatry,* 28(2), pp.99-125.

Webb, E.J., Campbell, D.T., Schwartz, R.D. and Sechrest, L., 1966. Unobtrusive Measures. Nonreactive Research in the Social Sciences. Chicago: Rand McNally.

Weinstein, H.M., Okin, R.M., Burnim, I. and Bazelon, D., 2000. *The Albanian mental health system* [Online]. California: Berkeley University. Available from: <www.law.berkeley.edu/HRCweb/download/Albania_Report.pdf> [Accessed December 11 2014].

Wenar, L., 2005. *The nature of rights. Philosophy & Public Affairs*, 33(3), pp.223-252.

Westbrook, M.T., Legge, V. and Pennay, M., 1993. Attitudes towards disabilities in a multicultural society. *Social Science and Medicine,* 36(5), pp.615-623.

Wilsford, D., 1995. Path dependency, or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of Health Policy,* 14(3), pp.251–83.

Wing, J.K. and Brown, G., 1970. *Institutionalism and Schizophrenia*. Cambridge: Cambridge University Press.

Wise, M. and Sainsbury, P., 2007. Democracy: the forgotten determinant of mental health. *Health Promotion Journal of Australia,* 18(3), pp.177-183.

World Bank, 2000. *Albania, Filling the Vulnerability Gap.* Washington DC: World Bank. Technical Paper No. 460.

World Bank, 2014. *Project Performance Assessment Report. Republic of Albania and Health System Modernization Project (P082814) and Social Sector Reform Development Policy Loan (P116937)* [Online]. Washington DC: World Bank. Available from: *http://ieg.worldbank.org/Data/reports/Albania_HealthSystemMod_SocialSectorReformDPL_PPAR_880740PPAR0P08050Box385272B00OUO090_0.pdf* [Accessed 3 December 2015].

World Health Organization, 2000. *Patients' rights and citizens and citizens' empowerment.* Through visions to reality: Joint consultation between the WHO Regional Office for Europe, the Nordic Council of Ministers and the Nordic School of Public Health. Copenhagen, Denmark (22-23, April 1999) [Online]. Geneva: World Health Organization: Available from: <http://home.broadpark.no/~wkeim/files/who-e69119.pdf> [Accessed 3 January 2015].

World Health Organization, 2001a. *Mental Health in Europe: Country Reports from the WHO European Network on Mental Health* [Online]. Geneva: World Health Organization. Available from: <http://www.euro.who.int/__data/assets/pdf_file/0016/156013/E76230.pdf> [Accessed 1 October 2014].

World Health Organization, 2001b. The World Health Report 2001. *Mental Health: New Understanding, New Hope* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/whr/2001/en/ [Accessed 11 October 2014].

World Health Organization, 2003. *Mental health legislation and human rights - Mental health policy and service guidance package* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/resources/en/Legislation.pdf [Accessed 13 December 2015].

World Health Organization, 2004a. *The World Health Report 2004. Changing History* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/whr/2004/en/ [Accessed 17 October 2014].

World Health Organization, 2004b. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization world mental health surveys. *JAMA,* 291(21), pp.2581-2590. DOI:10.1001/jama.291.21.2581.

World Health Organization, 2005b. *Mental Health Atlas 2005* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/evidence/atlas/profiles_countries_a_b.pdf?ua=1 [Accessed 3 December 2015].

World Health Organization, 2006. *WHO-AIMS report on mental health system in Albania. A report of the assessment of the mental health system in Albania using the World Health Organization - Assessment Instrument for Mental Health Systems (WHO-AIMS)* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/somaliland_who_aims_report.pdf [Accessed 12 May 2015].

World Health Organization, 2008a. *Policies and practices for mental health in Europe – meeting the challenges* [Online]. Geneva: World Health Organization. Available from: *http://www.euro.who.int/__data/assets/pdf_file/0006/96450/E91732.pdf* [Accessed 3 December 2015].

World Health Organization, 2008b. *Scaling Up Care for Mental, Neurological, and Substance Abuse Disorders* [Online]. Geneva: WHO. Available from: http://www.who.int/mental_health/mhgap_final_english.pdf [Accessed 3 January 2017].

World Health Organization, 2011. *Mental Health Atlas 2011* - Department of Mental Health and Substance Abuse [Online]. Geneva: World Health Organization: Available from: <http://www.who.int/mental_health/evidence/atlas/profiles/alb_mh_profile.pdf> [Accessed 1 October 2014].

World Health Organization, 2012a. *Global Burden of Disease 2010 Study* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/healthinfo/global_burden_disease/gbd/en/ [Accessed 3 December 2015].

World Health Organization, 2012b. *QualityRights Toolkit to assess and improve quality and human rights in mental health and social care facilities* [Online]. Geneva: World Health Organization. Available from: <http://www.who.int/mental_health/publications/QualityRights_toolkit/en/index.html> [Accessed 12 October 2014].

World Health Organization, 2013. *Investing in Mental Health: Evidence for Action* [Online]. Geneva: World Health Organization. Available from: http://apps.who.int/iris/bitstream/handle/10665/87232/9789241564618_eng.pdf;jsessionid=04A4D7ADE7D4D60AC5506639DDDC19A1?sequence=1 [Accessed 5 December 2016].

World Health Organization, 2014a. *European Health for All database (HFA-DB)* [Online]. Geneva: World Health Organization. Available from: http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db [Accessed November 12 2015].

World Health Organization, 2014b. *Global Health Observatory Data Repository* [Online]. Geneva: World Health Organization. Available from: http://apps.who.int/gho/data/node.country.country-ALB?lang=en [Accessed November 20 2015).

World Health Organization, 2016. *Mental Health Policy and Quality Rights* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/mental_health/policy/quality_rights/en/ Accessed 1 May 2016].

World Health Organization, 2017a. *Disability and health: Fact sheet No. 352.* Geneva: World Health Organization [Online]. Available from: http://www.who.int/mediacentre/factsheets/fs352/en [Accessed 3 December 2017].

World Health Organization, 2017b. *Social Determinants of Health* [Online]. Geneva: World Health Organization. Available from: http://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/ [Accessed May 5 2017].

Yamin, E.A., 2017. Democracy, Health Systems and the Right to Health: Narratives of Charity, Markets and Citizenship. *Harvard University Workshops: Petrie Flom Centre for Bioethics.* Boston: Harvard, pp.1-33.

Young, R and Collin, A., 2004. Introduction: constructivism and social constructionism in the career field. Journal of Vocational Behaviour 64(3), pp.373-388.

Zhang, S., Mellsop, G., Brink, J. and Wang, X., 2015. Involuntary admission and treatment of patients with mental disorder. *Neuroscience bulletin* [Online], 31. Available from: https://www.researchgate.net/publication/271023060_Involuntary_admission_and_treatment_of_patients_with_mental_disorder [Accessed Jan 20 2018].

APPENDICES

APPENDIX I: STUDY CONSENT FORM AND PATIENT INFORMATION SHEET

PART A. PARTICIPANT INFORMATION AND INFORMED CONSENT FORM

Study Title:	Do Albanian Mental Health Services Meet Human Rights Standards? A Critical Application of the WHO QualityRights Toolkit at Albania's Psychiatric Hospitals
BATH REB #: Hospital REB #:	
Principal Investigator:	Ms. Laura Loli-Dano
Institution:	University of Bath Claverton Down Rd, Bath, North East Somerset BA2 7AY, United Kingdom

PRINCIPAL INVESTIGATOR'S ORAL INTRODUCTION

My name is Laura Loli-Dano and I am a mental health professional and graduate student. I am working as part of a Visiting Committee. The purpose of the interviews I am conducting is to gather information and the perspectives of the staff, the users or residents and members of families (or friends or care providers) about this facility. If you agree to be interviewed, I will ask you questions about the facility itself, the care and treatment provided and the rights of people in the facility. I am an 'independent assessor'/student, which means that I do not have any ties or obligations towards any person or organization. I conduct my work independently and am not subject to any outside pressure in the way in which I conduct my work, nor can I be influenced to make inaccurate claims or withhold information about my findings or in my final report. Being an 'independent assessor' also means that nobody other than me and the team I am working with will know what you say to me. While we will be sharing our final report with the hospital management team, we will ensure your personal confidentiality is kept at all times within and beyond our report. In order to ensure that your identity is not divulged, your name will not be written on my interview tool and will not appear in the final report. If you inform me of a particular event or issue that you think will make it easy to identify you and with which you would rather not be linked, please let me know, and my team and I will make every effort to ensure that your identify is protected. I will ask you questions drawn from an instrument being prepared by the World Health Organization to assess and improve quality and human rights in mental health and social care facilities. I would like to tape this interview, but you are entitled not to have it taped. We will ensure that the tapes are not given to anyone outside this visiting team, and your name will not be linked to the recording. Again, no penalty, sanction or repercussions will occur if you decide you would rather not have the interview taped. If you agree to the interview being taped, please sign both part A and part B of the consent form overleaf. If you agree only to the interview but not to the taping of the interview, please sign only part A of the consent form overleaf. Please ask me any questions you have about this interview before signing the consent form. You may also stop me during the interview if you have any questions about it.

BACKGROUND & PURPOSE OF THE STUDY

You are being asked to take part in a research study. Before you decide to be a part of this study, you need to understand the risks and benefits. This consent form provides information about why the study is being done, what it will involve, and the possible risks and discomforts. The study investigator will be available to answer your questions and provide further explanations. If you agree to take part in the research study, you will be asked to sign this consent form. This process is known as informed consent. If you participate, you will receive a signed copy of this consent form. Your decision to take part in the study is voluntary. Should you decline to participate, your current and future treatment will not be affected in any way.

You are being asked to take part in a research study to help us understand how well the human rights of patients with mental disorders are protected and promoted at the 'Ali Mihali' Psychiatric Hospital in Vlora and the 'Sadik Dinci' Psychiatric Hospital in Elbasan. The aim of the study is to gather information and the perspectives of the staff, the users and residents and members of families (or friends or care providers), about the facility itself, the care and treatment provided and about the rights of people in the facility. The same process will be applied at two comparison study sites: the Vlora General Hospital and the Elbasan General Hospital, Surgery Unit. The World Health Organization's QualityRights Toolkit will be applied to assess patient human rights. The results of this study will provide important new information about whether Albania's psychiatric hospitals meet human rights standards. Findings regarding the state of patient human rights will inform recommendations to help improve quality of care provided to psychiatric patients. While we hope that this assessment will lead to improvements, we cannot guarantee

that areas you are unhappy with will be changed. Nevertheless, we will endeavour to use this information to bring about positive changes that may be needed.

YOUR ROLE IN THE STUDY

If you agree to take part in this study you will be asked to spend about one hour in a quiet room where you will answer questions provided by the study investigator. The standardized test questions aim to assess whether the hospital units adhere to human rights standards. The WHO Quality Rights Toolkit has been used in psychiatric research for a few years and asks about the degree to which patient human rights are protected in health care and social services settings. The WHO QualityRights Toolkit will be presented to you only once.

PARTICIPATION AND TERMINATION

Taking part in this study is entirely voluntary. You have the right to refuse to participate. If you decide not to take part for any reason, at any time, there will be no consequences, and your health care, if you are a patient at the hospital, will not be affected. You must let the investigator know of your decision to leave the study. You understand that you can stop this interview at any time should you wish not to continue and that this will be kept confidential and no penalty, sanction or repercussions will be incurred by you should you put an end to the interview. At all times your best interests will be upheld over the goals of the study. Your taking part in this study may be stopped without your consent by the investigator, the Research Ethics Board that approved the study, or by the regulatory authorities.

COMPENSATION

There is no financial compensation for this study.

POSSIBLE BENEFITS

While there are no immediate benefits from taking part in this study, the investigator anticipates that significant new information will emerge that will help inpatient psychiatric settings improve standards of care going forward. The ultimate goal is to enhance patient human rights protection and promotion. In addition, this study may help in the enhancement of quality of care of psychiatric services at this hospital for future patients with similar conditions.

POSSIBLE RISKS AND DISCOMFORTS

There are no significant risks related to the study. In some cases, participants might have strong emotional reactions to some of the questionnaire questions. Should this occur, one of the clinicians-in-charge supporting the study will meet with you to assess your comfort and safety and help with any clinical issues that might emerge from this, should you be a patient receiving care at these psychiatric settings.

CONFIDENTIALITY & PROTECTION OF PERSONAL INFORMATION

To ensure that the data from the questionnaires and medical records are kept private, you will be given a study ID number at the start of your participation. All research data will be kept private on a password-protected secure computer server. You understand that this consent form will not be linked to the interview tool and that your answers will remain confidential. The purpose of this interview has been explained to you, and you understand the contents of this form. The study investigator will store your signed Informed Consent form in a locked filing cabinet in a secure space.

You will not be identified by name in any manuscripts or presentations related to this research work. As part of continuing review of the research, your study records may be assessed on behalf of the Research Ethics Board. A person from the research ethics team may contact you (if your contact information is available) to ask you questions about the research study and your consent to participate. The person assessing your file or contacting you must maintain your confidentiality to the extent permitted by law. Your data may be analysed again at a later point.

Quality Assurance: As part of the Research Services Quality Assurance Program, this study may be monitored and/or audited by a member of the Quality Assurance Team. Your research records and hospital records may be reviewed during which confidentiality will be maintained as per hospital policies and the extent permitted by law.

DURATION OF STORAGE OF INFORMATION

Information Storage: Your information will be retained for ten (10) years from the end of the study period. At the end of this period, all study data including paper copies of questionnaires, electronic database, and other study documents that contain your personal information will be securely deleted. If you decide to withdraw your participation at any point in the study, you have the right to permit or restrict the use of your data for research purposes. If you should choose to limit the use of your data, then the information you provided during the study will no longer be used. Data collected may be re-analysed during these ten (10) years for another study.

Commercial Interests: At this time, this study is being conducted solely for scientific knowledge and there are no current plans to pursue commercial benefits. However, future collaborations that may result in financial returns are possible. Should this occur, you will not receive any benefit. Potential beneficiaries for possible commercial applications would include the study investigator and sponsoring institutions. Any future collaborations that may result in commercial returns will be based on the overall scientific results and will not identify you or any other participants at an individual level.

QUESTIONS ABOUT PARTICIPATION

If you have any questions about the study, please contact Principal Investigator, Laura Loli-Dano at [redacted]

RIGHT TO WITHDRAW FROM THIS STUDY

You are free to choose whether or not you want to take part in this study. You may decide not to begin, or to stop this study at any time. Your decision not to participate will not affect the way you are looked after and you will receive the medications and treatment already available for your condition, if you are a patient at the Albanian hospital units included in this study. Again, no penalty, sanction or repercussions will occur if you refuse to finish this interview. Some questions may be of a sensitive nature; if you do not wish to answer them, we can move on to the next question.

SIGNATURES

I have read this consent, which is printed in a language that I read and understand. I have been given sufficient time and opportunity to ask questions and to reflect on my understanding of the study with the study investigator. This study has been explained to my satisfaction and all of my questions related to the study procedures, possible risks and discomforts, benefits, maintenance of confidentiality and alternative treatments have been answered. By signing and dating this document, I freely and voluntarily agree to take part in this research study and grant direct access to my study and medical records. I agree to co-operate with the investigators and I consent to the use, collection and disclosure of information as outlined in this document band and I am aware that none of my legal rights are being waived. I freely give my consent and agree to participate in this study until I decide otherwise. I understand that I am free to withdraw from this study at any time, and that the decision not to participate will not affect the standard of care I receive.

I will receive a signed copy of this informed consent to keep as a reference about this study and whom to contact.

_____	_____	_____
Participant (Print Name)	Signature	Date of Signature
_____	_____	_____
Person Obtaining Consent (Print Name)	Signature	Date of Signature

INVESTIGATOR STATEMENT

I certify that I have explained the research study to the above individual, including the purpose, the procedures, the possible risks and potential benefits associated with participation in this research study in terms they can understand. Any questions raised have been answered to the individual's satisfaction. I believe that the participant fully understands my explanations and has freely given informed consent.

Laura Loli-Dano	_____	_____
Investigator (Print Name)	Signature	Date of Signature

PART B. CONSENT FOR THE INTERVIEW TO BE TAPE- OR VIDEO-RECORDED

I hereby agree to have this interview tape-recorded. I understand that my name will not be linked to the recording, and no one will be able to link me to the answers I give.

Name in block capitals: _____
Signature of participant: _____
Date: _____

PART C. CONSENT FOR PHOTOGRAPHS TO BE TAKEN DURING THE INTERVIEW

I hereby agree to having photographs taken (personal and/or the hospital setting). I understand that my name will not be linked to the photographs, and no one will be able to link me to the answers I give.

Name in block capitals: _____
Signature of participant: _____
Date: _____

APPENDIX II: STUDY FLYER

QualityRights Albania

What is the QualityRights Initiative?

In 2012, the World Health Organization launched WHO QualityRights, an initiative that aims to support countries to improve the quality of care and respect for human rights in mental health services. It is based on the United Nations Convention on the Rights of Persons with Disabilities which forms the basis for human rights standards that each service providing facility must respect, protect and fulfil. Several other countries have embarked on QualityRights which has led to significant quality improvements in the realm of patient rights.

The four key objectives of WHO QualityRights are:

- To assess and improve conditions in mental health services;
- To conduct capacity building of health professionals, people with mental health conditions and families on human rights, recovery and other areas through on-the-ground workshops and e-learning;
- To develop a movement of people with mental disabilities to provide mutual support, conduct advocacy and influence policy-making processes; and
- To reform national mental health policies and laws in line with international human rights standards.

What is the Aim of the QualityRights Study?

The aim of the QualityRights study is to assess the extent to which the human rights of patients with mental disorders are protected and promoted at the Vlora Psychiatric Hospital and the Elbasan Psychiatric Hospital, in Albania.

The assessment will be based on the standards of the WHO QualityRights Toolkit, which are as follows:

- ❖ The right to an adequate standard of living;
- ❖ The right to enjoyment of the highest attainable standard of physical and mental health;
- ❖ The right to exercise legal capacity and the right to personal freedom and the security of person;
- ❖ Freedom from torture, cruel inhumane or degrading treatment, punishment from exploitation, violence and abuse;
- ❖ The right to live independently and be included in the community

Who can partake?

Patients receiving care from either hospital, family members and staff can partake in the study. This is a collaborative study that aims to include views of all of these stakeholder groups while protecting their anonymity. In addition, reviewing selected patient charts, hospital policies and guidelines and other facility observations will be conducted. The individual interviews will last between 1-1.5hrs and will be conducted by an experienced mental health professional.

How can this study help?

Exploring and assessing the extent to which the human rights of people with mental health issues receiving care in Albania's psychiatric hospitals are protected and promoted will hopefully provide future directions regarding the promotion of patient human rights and enhanced access to quality care in these hospitals and across other mental health facilities in Albania. Study findings will be distributed to all three participant groups and other key stakeholders, i.e., hospital management teams, etc.

Contact Information:

Should you be interested in partaking in this study, and/or require additional study information, please contact: Laura Loli-Dano, Principal Investigator, at: +355 69374 6464.

APPENDIX III: Convention on the Rights of Persons with Disabilities

Source: (Adapted from) UN Enable. International agreement on the rights of disabled people. Easy read version. URL: *http://www.fedvol.ie/_fileupload/Next%20Steps/EasyReadUNConvention.pdf* Date Accessed 13/01/2016

Article 1 (Purpose of the Convention)

- This convention is an agreement which looks at what countries can do to make sure that people with disabilities have the same rights as everybody else.

Article 2 (definitions) - What the words mean.

- Communication - the ways that help people with disabilities to talk and understand information, for example computers, easy read or Braille.
- Discrimination - being treated unfairly or not getting the changes you need because you are disabled.
- Language - means any way people talk to each other including sign language.

Article 3 (General Principles) - The basic ideas of the convention. These are:

- People are free to make their own choices.
- No one will be discriminated against.
- People with disabilities have the same rights to be included in society as anybody else.
- People with disabilities are to be respected for who they are.
- Everyone should have equal opportunities.
- People with disabilities should have equal access and opportunities as everyone else (eg. to health services, to employment, to education, to vote etc.).
- Men and women should have equal opportunities.
- Disabled children should be respected for who they are as they grow up.

Article 4 (General Obligations) - What countries should do?

- All countries should make sure that people with disabilities actually do get treated equally.
- They agree to do this by:
    - Making new rules and laws to give people with disabilities their rights and change any bad ones.
    - Making sure the rights of people with disabilities to be treated equally are included in the law.
    - Including disability issues in all policies.
    - Not doing things that are against this convention.
    - Making sure governments and authorities do the things in this convention.
    - Doing as much as they can to make sure no one discriminates against people with disabilities.
    - Making sure things are designed for everyone to use or that can be easily changed.
    - Using new technology to help people with disabilities.

    - Giving accessible information to people with disabilities about the things that will help them.
    - Training people about this convention.

- All countries should do as much as they can afford to make sure people with disabilities are not discriminated against.
- All countries should involve people with disabilities in making new laws and policies.

Article 5 (Equality and non-discrimination) - Being equal.

- Countries agree that everyone is equal under the law and that discrimination against people with disabilities will not be allowed.

Article 6 (Women with disabilities) - Women with disabilities being treated equally.

- Countries agree that women and girls who are disabled are treated unfairly in lots of different ways.
- Countries will work to make sure that disabled women and girls have full, free and equal lives.

Article 7 (Children with disabilities) - Children with disabilities being treated equally.

- Countries agree that disabled children have the same rights and freedom as other children and are treated equally with others.
- What is best for the child will be the most important thing to think about.
- Countries agree that disabled children have the right to be heard in all things that can affect them in their lives.
- Support will be given to children to help make this happen.

Article 8 (Awareness raising) - Giving people information about disability.

- Countries should help people realise the equal rights of people with disabilities and show what people with disabilities can do.
- They should do this by:
    - having campaigns to change the way some people think about people with disabilities lives and things like getting married or having sex.
    - Showing what jobs people with disabilities can do.
    - Teaching all children about equal rights for people with disabilities.
    - Getting the media to talk about and show people with disabilities properly.
    - Supporting more disability awareness work.

Article 9 (Accessibility) - Countries should make sure people with disabilities have better access to things in all areas of life.

- There should be better access (for e.g. for people in wheelchairs) to public buildings like hospitals and schools, and transport.
- Signs should be written in simple, easy to read language and in Braille.
- More guides and sign language interpreters should be available in public buildings.
- There should be guidelines about how to make access to public services better.

- Accessibility training should be given.
- They should make sure that people with disabilities have access to new technology.
- They should make sure information is made accessible from the beginning.
- They should make sure that people with disabilities get the right support to getting the information they need.

Article 10 (Right to life) - Everyone has the right to life including people with disabilities.

- Countries should make sure people with disabilities have the same chances as anyone else to live their lives.

Article 11 (Emergencies)

- Making sure that people with disabilities are properly protected when there are risky situations for everyone, for example when hurricanes happen.

Article 12 (Equal recognition before the law) - This means being treated equally by the law.

- People with disabilities are to be respected by the law like everyone else.
- People with disabilities have the same right to make their own decisions about important things as everyone else.
- People with disabilities should have the proper support they need when making decisions.
- If a person needs help in making decisions there should be rules to make sure this is done properly.
- People with disabilities have equal rights to:
    - Own or be given property.
    - Control their own money.
    - Be able to borrow money the same as anyone else.
    - Not have their homes or money taken away from them.

Article 13 (Access to Justice) - Getting justice.

- People with disabilities should have the same rights to go to court, take other people to court or take part in what happens in courts as anyone else.
- People with disabilities should get support to make sure they get these rights.
- Countries should have special training for courts, police and prison staff.

Article 14 (Liberty and security of person) - This means being free and safe.

- People with disabilities should be free and safe like everyone else.
- Governments should make sure that people with disabilities have their freedom protected by law, the same as all other people
- People with disabilities should not be locked up just because they have a disability.
- They should also have the same rights that everyone else has under other international laws.

Article 15 (Freedom form torture or cruel, inhuman or degrading treatment or punishment) - This means not being tortured or treated cruelly

- People with disabilities must not be treated cruelly or tortured.
- People with disabilities must not be experimented on, including through medical experiments, (unless they freely agree).
- Countries must do everything possible to make sure these things do not happen.

Article 16 (Freedom from exploitation, violence and abuse) - This means not being used or abused:

- Countries must make laws and rules to make sure people with disabilities are protected in the home and outside from violence, being used or abused.
- Countries must also try to prevent abuse and they should make sure there is proper support, information and training on how to see abuse and how to report it.
- Countries should make sure that services that support people with disabilities are properly checked up on to make sure abuse does not happen.
- Countries should make sure that people with disabilities who have been abused get the help and support they need to keep them safe and help recover from the abuse.
- Countries must make sure they have good ways of finding out about abuse and making the abusers go to court.
- Countries must think especially about the abuse of women and children.

Article 17 (Protecting the integrity of the person) - Treating people with disabilities as people first.

- People with disabilities should be treated like anyone else, with the same respect and rights as others.

Article 18 (Liberty of movement and nationality) - Moving around.

- People with disabilities have the right:
  - To decide where they live and to move about the same as everyone else.
  - To belong to a country (be a citizen) and not have that taken away because they are disabled.
  - To have papers, like passports, that other people have.
  - To leave any country including their own.
  - Disabled children will have the right to a name from birth, a right to be a citizen and if possible, the right to know and be cared for by their parents.

Art 19 (Living independently and being included in the community) - This means that countries should make sure people with disabilities have the same choices as everyone else about how they live and being part of their communities.

- People with disabilities can choose:
  - Where they live, the same as everyone else.
  - Who they live with, the same as everyone else.
  - And not to live in a particular place like a hostel, hospital or home if they don't want to.
  - From a range of different support services including personal assistance.

    - From the same range of services that other people without disability can choose from (eg. housing, health, employment services) and get a good service.

Article 20 (Personal mobility) - Getting about.

- Countries should make sure people with disabilities can get about independently as much as possible.
- They should:
    - Help people get about.
    - Help people get good aids and help to get about.
    - Make sure these things don't cost too much.
    - Give training on how to get about.
    - Get companies that make aids to think about all different needs of people with disabilities.

Article 21 (Freedom of expression and opinion, and access to information) - Saying what you want and access to information.

- Countries must make sure that people with disabilities have the right to find out and give information and to say what they want, the same as everyone else.
- This includes:
    - Information in the way you need it, easy-read for example.
    - Providing sign languages, Braille and other ways of information.
    - Telling other services to do accessible information.
    - Getting the media, including the Internet to provide accessible information.
    - Supporting the use of sign language.

Article 22 (Respect for privacy)

- People with disabilities have the right to a private life and no one should interfere with or get in the way of that.
- Countries must make sure that personal information about people with disabilities is kept confidential or private the same as everyone else's.

Article 23 (Respect for home and the family) - This means that countries must make sure that people with disabilities have equal rights to marriage, a family and personal relationships.

- Countries must make sure that:
    - People with disabilities have equal rights to get married and start a family as long as both of the couple want to.
    - People with disabilities have a right to decide how many children they have and when to have them, and not be sterilized against their will.
    - People with disabilities have the right to family planning and other information to help them decide these things.
    - Children with disabilities have the right to stay with their family and not to be kept apart from their families.
- Countries will provide support to people with disabilities to help bring up their children.
- Countries must support disabled children and their families.

- Countries will make sure children are not taken away from their parents if they don't want to be, except when the law says it is in the best interests of the child.
- Children must not be taken away just because they or their parents are disabled.

Article 24 (Education) - This means people with disabilities have a right to education.

- Countries will make sure people with disabilities have the opportunity to go to mainstream schools and can carry on learning throughout their lives so that:
    - People with disabilities are able to develop their skills and abilities and take their place in the world.
    - People with disabilities are not excluded from (kept out of) any sort of education.
    - People with disabilities can go to good local schools, and don't have to pay for them, the same as everyone else.
    - People with disabilities have their needs met as far as possible.
    - People with disabilities get proper support to learn.
    - People can learn Braille and other ways of communicating as needed
- Sign language should be taught to people, and it should be seen and accepted as a language of the deaf community.
- Children who are deaf or blind should get the right education and support for them to learn.
- Countries need to make sure teachers have the right skills to teach people with disabilities.
- Countries should provide the right support for people with disabilities to continue their education as adults if they want to.

Article 25 (Health) - This means people with disabilities have the right to access to health services including family.

- Countries will:
    - Make sure people with disabilities have access to the same health services as others.
    - Make sure people with disabilities get the health services they need because of their disability.
    - Make sure services are near to where people live.
    - Make sure health professionals give the same service to people with disabilities as to others.
    - Make sure people with disabilities are not discriminated against in health and life insurance.
    - Make sure people are not refused care or treatment because they are disabled.
    - Make sure that health professionals ask people with disabilities for their informed consent to treatment.

Article 26 (Habilitation and rehabilitation) - This means people with disabilities have services to help them recover and be able to live in the community.

- Countries will make sure people with disabilities can lead an independent and healthy a life as possible and will provide support in health, work, education and social services to help that happen.

- Countries will make sure that they look at people with disabilities needs and strengths at an early stage so that people with disabilities get the support and services they need.
- These services will be as near to where people with disabilities live as possible.
- Staff will be trained to do a good job.
- Countries will make available different aids and equipment made to support people with disabilities to recover and live in the community.

Article 27 (Work and employment) - This means people with disabilities have a right to work, equal with others.

- Countries will do more to get people with disabilities work and will help do this by:
  - Making laws that make sure people with disabilities are treated equally and fairly at work.
  - Making sure people with disabilities have equal job rights and rules and pay.
  - Making sure people with disabilities have a right to join a union the same as everyone else.
  - Making sure people with disabilities can go on work programmes and work training.
  - Helping people with disabilities find and keep jobs as well as get better jobs.
  - Helping people with disabilities set up their own businesses.
  - Giving disabled workers jobs with Government and in places like councils and hospitals.
  - Helping companies give people with disabilities jobs.
  - Making sure people with disabilities have suitable places to work.
  - Making sure people with disabilities can try out work.
  - Help people with disabilities get back to work.
  - Countries must make sure that people with disabilities are not forced to do unpaid work.

Art 28 (Adequate standard of living and social protection) - This means people with disabilities have an equal right to satisfactory and acceptable standard of living/living conditions for them and their families. This includes food, clothing, housing and clean water.

- People with disabilities should be able to get help to improve their standard of living/living conditions the same as everyone else.
- Countries should make sure that:
  - People with disabilities have the right services and aids for their disability, at a price they can afford.
  - People with disabilities especially girls and women and older people, have help to have a satisfactory and acceptable standard of living.
    People with disabilities who are poor get help from the state with the costs of disability.
  - People with disabilities have access to public housing programmes.
  - People with disabilities have the same chances to get retirement pensions as other people.

Art 29 (Participation in political and public life) - This means people with disabilities have the right to take part in politics the same as everyone else.

- People with disabilities have the right to vote by:
    - Making sure voting is easy to do and understandable to people with disabilities.
    - Making sure voting is secret.
    - Allowing support to help people with disabilities to vote when they need it.
    - Making sure people with disabilities can be involved in non-government organizations and political parties.
    - Making sure people with disabilities can join organizations of people with disabilities.
    - People with disabilities have the right to stand for election as MPs and councilors.

Art 30 (Participation in cultural life, recreation, leisure and sports) - This means people with disabilities have the right to take part in sports and leisure as much as anybody else.

- Countries should work towards making sure that:
    - Things like books are accessible.
    - Television, films and theatres are accessible.
    - People with disabilities can get into places like museums.
    - People with disabilities have the opportunity to be artists in their own rights
    - Rules and laws should not make it more difficult for people with disabilities to access things like books or films.
    - Deaf and other cultures are respected and accepted as culture.
    - People with disabilities are supported to take part in recreational, leisure and sporting activities.
    - People with disabilities are able to take part mainstream recreational, leisure and sporting activities as well as in special disability focused recreational, sporting and leisure activities.
    - Places where sports, recreation and leisure take place should be physically accessible to people with disabilities.
    - Disabled children have equal access to these activities as well.

APPENDIX IV: WHO QualityRights Toolkit [abbreviated version – (WHO, 2012b)]

Theme 1. The right to an adequate standard of living [Article 28 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD)]

Standard 1.1 The building is in good physical condition.

Standard 1.2 The sleeping conditions of service users are comfortable and allow sufficient privacy.

Standard 1.3 The facility meets hygiene and sanitary requirements.

Standard 1.4 Service users are given food, safe drinking-water and clothing that meet their needs and preferences.

Standard 1.5 Service users can communicate freely, and their right to privacy is respected.

Standard 1.6 The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.

Standard 1.7 Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

Theme 2. The right to enjoyment of the highest attainable standards of physical and mental health (Article 25 of the CRPD)

Standard 2.1 Facilities are available to everyone who requires treatment and support.

Standard 2.2 The facility has skilled staff and provides good-quality mental health services.

Standard 2.3 Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community.

Standard 2.4 Psychotropic medication is available, affordable and used appropriately.

Standard 2.5 Adequate services are available for general and reproductive health.

Theme 3. The right to exercise legal capacity and the right to personal liberty and the security of person (Articles 12 and 14 of the CRPD)

Standard 3.1 Service users' preferences regarding the place and form of treatment are always a priority.

Standard 3.2 Procedures and safeguards are in place to prevent detention and treatment without free and informed consent.

Standard 3.3 Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity.

Standard 3.4 Service users have the right to confidentiality and access to their personal health information.

Theme 4. Freedom from torture or cruel, inhuman or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)

Standard 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect.

Standard 4.2 Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.

Standard 4.3 Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user.

Standard 4.4 No service user is subjected to medical or scientific experimentation without his or her informed consent.

Standard 4.5 Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse.

Theme 5. The right to live independently and be included in the community (Article 19 of the CRPD)

Standard 5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community.

Standard 5.2 Service users can access education and employment opportunities.

Standard 5.3 The right of service users to participate in political and public life and to exercise freedom of association is supported.

Standard 5.4 Service users are supported in taking part in social, cultural, religious and leisure activities.

APPENDIX V: QUALITYRIGHTS TOOLKIT QUALITATIVE THEME FINDINGS OF ALL HOSPITALS

SECTION 1: "ALI MIHALI" VLORA PSYCHIATRIC HOSPITAL FINDINGS

QualityRights Toolkit Theme/Standard 1: The Right to An adequate Standard of Living and Social Protection

Theme/Standard 1 is comprised of the sub-standards captured in Table 1 below:

Table 1. Theme/Standard 1 Sub-standards

Theme/Standard 1: The right to an adequate standard of living and social protection						
S: 1.1 The building is in good physical condition	**S: 1.2** The sleeping conditions of service users are comfortable and allow sufficient privacy	**S: 1.3** The facility meets hygiene and sanitary requirements	**S: 1.4** Service users are given food, safe drinking-water and clothing that meet their needs and preferences	**S: 1.5** Service users can communicate freely, and their right to privacy is respected	**S: 1.6** The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction	**S: 1.7** Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

Tables below provides an overview of study participants' frequency of reported qualitative themes.

Table 2. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Mixed quality of living conditions, a daily reality <u>Subthemes:</u>	**1,2,3**	
Decent bedroom conditions and indoors in newly built buildings	1,2,3	It is winter and cold outdoors, but it is warm and comfortable indoors, which I like it. There is plenty of light even in my room. I can't complain as I also have a washroom and shower in my room (Service user)

		I can shower as many times as I want. I have a shower in my bedroom and I take showers myself, staff do not have to remind me to bathe. (Service user) The beds, sheets and blankets are new and we get clean sheets every week. (Service user) It is almost like eating at home. Everyone goes to the cafeteria to eat.. (Service user)
Overcrowded chronic inpatient units as realities of inhumane conditions	1,2,3	We have 10 guys in the room where we sleep. We all try to sleep there but it is noisy with men yelling, talking to themselves (I don't talk to myself) and farting. .(Service user) Overcrowding is a problem, amongst others in the old buildings. Patients have no privacy and that in itself presents with safety issues. (Member of staff)
Existence of bare life necessities, starting from kitchen conditions in chronic and sub-acute units	1,2,3	The food is alright, not exactly like a home cooking. I eat veggies, meat, fruit, and bread and drink coffee. The clothing I am given belongs to me. (Service user) The bed and the room where she sleeps is fine. As a parent it is one less worry for me that my daughter is not staying in a rundown room. (Family member)
Rundown rooms/washrooms/showers in chronic and sub-acute units	1,2,3	'We've got no heating in our room and it is so cold and dark. The light bulb in the middle of the room does not work as it has not been fixed yet. In order to warm up I go to the front of the building when it is sunny like today. In order to stay warm I cover my head with a blanket, as do my other roommates when we go back to our room.." (Service user) 'It is indeed cold in these buildings. Even the staff can't wait until the new buildings are up. As you can tell these building are very old and the plan is to demolish them.." (Member of staff)

Violence amongst service users and lack of physical safety in overcrowded units	1,3	….Showers are ugly, walls are ripped off in some places and water is not always running enough to take a shower. (Service user) …..We try to stop them when fighting, but often they are very strong and are in big groups. They share rooms where 10+ patients live. The unit is on one floor with only a few rooms and is overcrowded with so many patients.. (Member of staff) Fights spread out pretty quickly and patients get hurt, i.e., teeth broken, as well as staff, i.e., hit on the head, or grabbed. We try to de-escalate and stop these fights as soon as possible. (Member of staff)

Table 3. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	Study Group Reporting Theme	Illustrative Quotations
Infringement of personal freedom and privacy <u>Subthemes:</u>	**1,2,3**	
Limited sense of freedom (movement, communication, choice)	1,2,3	Staff does not let me spend much time outside. I don't know why (Service user) Don't like it this way, even though the clothes I'm given it's clean…What's wrong with wearing my clothes (Service user)
Mandatory clothing, a feature of inpatient units	1,2,3	All patients go to bed at the same time in the evening and at siesta time. Not everyone likes it though, but they need rest and order since it is so many of them (Member of staff)
Lack of privacy in overcrowded units	1,2,3	She (my daughter) does not need to keep anything here as we take her belongings home as she is not allowed to keep anything here. There is no privacy for her for sure (Family member) Most men are in rooms with 10+ men in it, which is super crowded. This is a problem for patients and for us. For them as they have absolutely no privacy, each other's behavior irritates each other, eg, snoring, talking to themselves, etc, etc. (Member of staff)

Table 4. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Infringement of enjoyment of personal and social life, as grounds for action	**1,2,3**	
<u>Subthemes:</u>		
Limited enjoyment of hospital based services, indoors and outdoors	1,2,3	You must have seen the TVs in our waiting area. Can't stand it as I can't watch what I want. Every almost wants to watch what they like…What else can I do when it's cold outside….(Service user) In the ergo therapy room, patients can play games, sew, draw, speak to staff, write, etc. They also benefit from group therapy where we serve max 12 patients in one group (Member of staff) I've not heard about any fun activities happening inside or outside of here though…(Service user)
Limited community engagement, depending on service functionality	1,3	I don't go outside the hospital much. I have Turkish coffee at Turi's caffee. Staff take use there and I love it. I have been by the seaside. It is so nice (Service user) Patients whose behavior is manageable outdoors can go outdoors for few hrs, we take to city on picnics, i.e., being by the seaside to have some coffee at a cafe which they love very much. Most patients want to leave though (Member of staff)
Family support and family abandonment	1,3	A few family members take their loved ones home for few days, few bring them back earlier than expected as they could not manage them. A lot of chronically patients are completely abandoned for years by their family members (Member of staff) No one takes me home. My family members have not seen me for a long time (Service user)
Stigma (service user, family members, staff)	1,2,3	My family members are upset about what I did…. They think I am crazy...that's why I deserve to be left alone here (Service user) Bringing your child to a psychiatric hospital, is the nightmare of any parent, I would imagine. It means

		your child is crazy….that's what people think. You can go for a heart surgery and get out of that hospital, after you pay some money, but you feel better. Here, though it is a different story. You may not pay any money, but there is no guarantee you'd feel better (Family member)

QualityRights Toolkit Theme/Standard 2: The Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health

Table 5 provides the sub-standards of Theme/Standard 2.

Table 5. Theme/Standard 2 Sub-standards

Theme/Standard 2: The right to enjoyment of the highest attainable standard of physical and mental health				
S: 2.1 Facilities are Available to everyone who requires treatment and support	**S: 2.2** The facility has skilled staff and provides good-quality mental health services	**S: 2.3** Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community	**S: 2.4** Psychotropic medication is available, affordable and used appropriately	**S: 2.5** Adequate services are available for general and reproductive health

Tables below provides an overview of study participants' frequency of reported themes.

Table 6. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Voluntary and involuntary admissions key features of admission process	**1,2,3**	
<u>Subthemes</u>		
Reported challenges regarding both voluntary and involuntary admissions cases	1,3	I have not had a problem getting help here. My problem is I don't want to be here. Entering this place, I think, is not a problem, leaving this place, is a problem. I don't understand why they keep me here (Service user) I hear other women and men not wanting to be here, complaining of not being able to leave this place (Service user)

Admissions based on laid out inclusion criteria	3	We admit anyone in our facility who comes via the following paths if they have a mental illness which we treat here: - Emergency room - Family Physician - District Psychiatrist - Psychiatrist located in Community Mental Health Centers - Accompanied by a family member - Accompanied by the police (Member of staff)

Table 7. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Variable quality of care in a predominating institutionalized and medically oriented model of care	**1,2,3**	
<u>Subthemes</u> Mixed quality staff responsiveness and attitude (access to physicians and others)	1,2,	I see my doctor here, the nurses, the social worker, the psychologist (the latter I like better than nurses as she listens to me) (Service user) Nurses never forget to give it (the medication) to me…..(Service user) My doctor has told how harmful taking cocaine is for my health. I did not think that way when I used cocaine though. I have changed my mind about it now. I guess any substance is not good for the health…..(Service user) They are ok, sometimes some staff's tone is a bit harsh, I guess they have to make sure all of us take the medication, hence, being harsh sometimes… I would not know who to speak about this matter anyways….(Service user)
Long standing hospitalization impacts treatment	3	There male patients in chronic units who have been here since 1984, and females in chronic female units since 1981. You can't expect progress for people who have been here that long…such hospitals were used as punitive places in the past system….(Member of staff)

Staff shortage as a barrier to quality of care	1,2,3	We have files for patients, but not necessarily complete treatment plans, it's not our regular practice, it is few of us and not enough time to work and complete plans as well (Member of staff) We offer group therapy as well for up to 12 people in a group, it's never enough for all our patients, too many of them given our staffing numbers. Patients are also seen by the psychologists and social workers who offer psycho-social services. We don't have expertise on evidence-based modalities, as CBT. Our groups focus on skills training and setting life goals. (Member of staff) I want to talk longer to the psychologist but she does not have much time for me, she says she has to see other patients too. I see her every few days (Service user) Just few of us working on a shift is not enough to manage very agitated patients properly (Member of staff)
Availability of medication and health services and partial counsel on their role	1,3	I have not paid any money being here so far, not for the food, the medication or for the bedroom where I stay in (Service user) I see a dentist around, but have not been to see him yet……the dentist does not replace missing teeth. What good is this service then for? I have my own dentist who I see in the city (Service user) Nurses never forget to give it (the medication) to me…..(Service user) I have reservations about the medical staff work. My son does not seem better than when he came here. He is very sleepy and communicates little. They should do a lot more for him. I understand it is the medication, but can't the doctors find a better solution, medication wise? The doctor has not even said anything if the medication works or not, or what it may cause (Family member)
Limited health promotion and reproductive health education	1,2,3	I had some blood work done when I first came in. There are some anti-smoking signs around….Lots of us smoke outside the hospital though, doctors, too…(Service user) Health promotion is done depending on season, needs, etc, eg, winter for flu shots, patient needs,

Partial compliance with documentation guidelines	3 (including file observation)	e.g., diabetic patients for healthy diets, etc. (Member of staff) I don't recall us offering any reproductive health education, at least not for the chronic patients… (Staff)

Table 8. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Lack of knowledge of CRPD and limited knowledge of service user rights <u>Subthemes:</u>	1,2,3	You ask about patient rights and CRPD. I had never heard of CRPD, the first time I hear about it. Well, we've had some training on what rights do patients have, similar to doctors signing the Hippocratic Oath, we….. are licensed in our professions and are expected to be professional with patients and treat them with respect (Member of staff)
Lack of knowledge of CRPD	1,2,3	
Lack of and/or limited knowledge of service user rights	1,2,3	I know nothing about my rights. My lawyer says I have some rights, too, but don't know what they are….(Service user) As for my son's rights, I don't know what these rights are while he is here. I would assume he must be treated like a human being while he is here (Family member)
Presence of mechanisms to attend to service user rights	3	There is a big poster on the first floor speaking to denouncing corruption in Health Care…..As soon as you enter the building, there is a patient satisfaction survey box with flyers which patients and their loved ones can complete and drop it in the box. In addition, we have the Ombudsman who visits us once a year and prepares recommendations about our services (Member of staff)

Table 9. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Stigma, a quality of life deteriorating factor <u>Subthemes:</u>	**2**	
Stigma (Family member's)	2	We have patients though whose families feel ashamed of and don't want them back as they are disruptive or engage in fights with others. We had a case like this yesterday and the family member dropped his brother off here asking to hospitalize him as he shames the family when he offends others in the neighbourhood (Staff speaking to family stigma)

QualityRights Toolkit Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person

Table 10 provides the Sub-standards of Theme/Standard 3.

Table 10. Theme/Standard 3 Sub-standards

Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person			
S:3.1 Service users' preferences regarding the place and form of treatment are always a priority	**S:3.2** Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	**S: 3.3** Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	**S: 3.4** Service users have the right to confidentiality and access to their personal health information

Tables below provides an overview of study participants' frequency of reported themes.

Table 11. Theme/Standard 3 Qualitative Data Findings
Study Participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Lack of mechanisms to support service users informed decision making, a key feature of treatment model	**1,2,3**	
<u>Subthemes:</u>		
Pre-determined access point of health care	1,2,3	Patients are served based on their area of residence. There are exceptions though, such as: we see anyone who is 18 years and older. We refer youth to Tirana Psychiatric Hospital as staff there have expertise in treating such patients there. All patients with criminal charges these days are sent to Kruja Psychiatric Forensic Hospital. Developmentally delayed patients are also sent to Tirana Psychiatric Hospital. Other than those cases, we have admitted any other cases which have requested our services, but if the patient needed to get transferred elsewhere, we'd keep the patient for 1-2 nights, and then transfer (Member of staff)

Psychiatrists key determinants of course of treatments	1,2,3	Because of this being a psychiatric hospital, the main line of treatment is medication as determined by our psychiatrists (Member of staff)
Limited community infrastructure does not facilitate de-hospitalization of service users	1,2,3	Just 3 supported homes in Vlora, if only we could discharge more patients (Member of staff)
Lack of formal procedures and processes to support service users increase awareness and understanding of their rights	1,2,3	I've told few times, I am held against my wishes. I get it, I was using cocaine before and perhaps that's why my family brought me here. I don't understand why I am kept here for so long. Should I not have the right to know what will happen to me? No one will explain it to me (Service user) We obviously need to do things which you are asking about as whether patients have any written material on their rights, which they have none (Member of staff)

Table 12. Theme/Standard 3 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Violation of involuntary procedures despite existing written protocols, in contravention with national and international laws <u>Subthemes:</u>	**3**	
Admissions criteria exist for involuntary admissions	3	Most patients consent to treatment either upon arrival, or within 2 days of being in the hospital, even though they may not consent from the moment they arrive (Member of staff) Patients who refuse treatment, the hospital is obligated to notify the District Court for a legal representative to meet with patient and have the

		case reviewed by the judge to determine patient suitability for involuntary treatment. We are obligated to do so within 2 days from the admission date and complete all the required paperwork and document everything on patient's chart (Member of staff)
Violation of involuntary admission protocols	1	My problem is not being able to go, as I am held against my will. I did not sign any papers when I came here, I remember this much (Service user)
Use of violence in admissions and stigma (Service user's)	1	Listen, I stole some money, and my family brought me here. In xxxxx I was using some drugs too, and my family did not like it. It's like they could not wait to get me here. As soon as my family brought me here, staff took me in right away. They were very rude and rough with me….they kicked me, they grabbed me by my hair as I did not want to be here…….. What wants to be here, anyway? That person will have to be crazy to want to stay here, isn't that so? (Service user)
Lack of support person and/or community representatives supporting service users	1,2,3	There is no third party who can represent patients and/or work with them to ensure that their voice is heard. I have never heard of a patient advocacy officer, which you mention. The Mental Health Act states that patients and family members can appeal the process with the relevant judiciary institutions. In saying it, I am not sure how this could happen when patients are so unwell and don't know the mechanisms how to appeal (Member of staff)
Present confidential files for service users with access by staff only	3	We have files for each patient which are kept in the files room. The active files are kept in the Chief of Nursing office (Member of staff)

QualityRights Toolkit Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, or punishment from exploitation, violence and abuse

Table 13 provides the sub-standards of Theme/Standard 4.

Table 13. Theme/Standard 4 Sub-standards
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, or punishment from exploitation, violence and abuse				
S: 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect	**S: 4.2** Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	**S: 4.3** Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user	**S: 4.4** No Service user is subjected to medical or scientific experimentation without his or her informed consent	**S: 4.5** Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse

Tables below provides an overview of study participants' frequency of reported themes.

Table 14. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Protection and violation of service user on the part of staff, part of service user experience <u>Subthemes:</u>	**1,2,3**	
Protection of service users on the part of staff	1	Only when someone hits me, I try to defend myself, staff defend me too……when I get nervous I tell staff, and they take me for a walk (Service user)
Violation of service user on the part of staff and from patient to patient	1,3	We work as a team and share information on triggers with each other so that we can best prepare to handle other challenges. However, often fight erupt so suddenly between patients that we don't get to understand what the trigger was and end up getting hurt ourselves as well (Member of staff) Our job is a human job, trying to serve people who are most vulnerable is something that not everyone would do well, I think. It is not just the pay that keeps me here, I feel I help out in this field. Now, there are patients and family members who are loud about what they get here, similar to patients in general hospitals. If I was not happy there, I'd say something (Member of staff) ..As soon as my family brought me here, staff took me in right away. They were very rude and rough with me….they kicked me, they grabbed me by my hair as I did not want to be here…….(Service user) I don't know of any staff abusing patients (Member of staff)
No ECT use and/or medical experimentation	3	No ECT done here (Member of staff)

Table 15. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	Study Group Reporting Theme	Illustrative Quotations
Mixed restraint forms used with service users <u>Subthemes:</u>	**1,2,3**	
Use of physical and chemical restraints	3	We have not used the isolation room in 2016, and have been chemical restraint free for 2 years, except for few cases, i.e., in cases of schizophrenia. We try hard not to restrain patients when agitated. However, in the emergency room, in 2016 we had 16 straightjacket cases, and 4 cases in the sub-acute unit. The other way of restraining is via using the belts and bed sheets in bed, for max 15 mins, with the doctor present and with the doctor's directive. This is all documented in the relevant form as per funder's requirements and noted on patient chart as well. These incidents are not reported externally. The unit chief is made aware of these incidents as well. (Member of staff)

Table 16. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	Study Group Reporting Theme	Illustrative Quotations
Staff dissatisfaction, a general sentiment amongst staff <u>Subthemes</u>	**3**	
Monetary reprimands and fear of repercussions	3	….staff have to make sure patients don't destroy hospital furnishings, otherwise they pay out of their pocket which is unfair. Our salaries are low to begin with, let alone covering the cost of furniture damaged. It is the management team's rule…… I don't want to complain much as I don't want to cause job problems… (Member of staff)
Lack of protection in the workplace	3	Hence, I try to defend myself and the property with not much help, just few other colleagues who may step in and help (Member of staff)

Table 17. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Limited application of mechanisms promoting service user rights, non-compliant with contemporary standards	**1,2,3**	
<u>Subthemes</u>		
Formal processes with lack of proactive and ongoing promotion of service rights	1,2,3	
Limited presence of an independent body	3	I shared earlier the Ombudsman visits our hospital and makes recommendations yearly (Member of staff)
Lack of legal representation/service user advocates	1,2,3	There is no legal representation made available, and there are no organizations which represent patient rights here. …….(Member of staff)
Limited access of service users to complaint mechanisms	3	No, I don't know what to do if I had a complaint. Most likely, I would tell my doctor. No one has said anything about my rights either (Service user)
No disclosure of data on service users abuse/neglect and/or any disciplinary action against any person with history of service user abuse/neglect	3	I don't know of any staff abusing patients (Member of staff)

QualityRights Theme/Standard 5: The right to live independently and be included in the community

Theme/Standard 5 is comprised of the sub-standards captured in Table 18 below:

Table 18. Theme/Standard 5 Sub-standards

Theme/Standard 5: The right to live independently and be included in the Community			
S: 5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community	**5.2** Service users can access education and employment opportunities	**S: 5.3** The right of service users to participate in political and public life and to exercise freedom of association is supported	**S: 5.4** Service users are supported in taking part in social, cultural, religious and leisure activities

Tables below provides an overview of study participants' frequency of reported themes.

Table 19. Theme/Standard 5 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Serious lack of community infrastructure to support de-institutionalization	**2,3**	
<u>Subthemes</u>		
Lack of community resources to respond to treatment needs in the case of deinstitutionalized patients	1,3	We want to have as many patients who get discharged to be able to get some trades training and then work. It's challenging though, quite a bit as even places which may have some work, they won't hire our ex patients due to stigma. That's why we have a long way to go as a society (Member of staff) There is a significant lack of community based infrastructures for these patients. We help patients apply for disability pension, or

		social assistance as per need basis (Member of staff) I have my home where I can return to, even though my family may not want me back right away as we have conflicts, I become nervous with them. I can have my own money too, I don't need anything else. Perhaps money to get medication when I get out of here. staff can help with that (Service user) The prefecture, the government has to build new community based homes for patients to get discharged to. If possible, for them to spend some time there before they go back to their families. A kind of a group home I have in mind which is some kind of step down treatment from the one offered in hospital (Member of staff) I recall very few patients who were more able to work than others, right before they would leave the hospital. I am not talking about any complex jobs, but the ones like construction or lifting heavy stuff. I don't know of anyone being so well that they would start schooling after leaving our hospital….(Member of staff)

Table 20. Theme/Standard 5 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Lack of resources, a serious limiting factor	**2,3**	
<u>Subthemes</u>		
Lack of funding	2,3	We provide information on activities which we can afford taking patients to. It may not sound great, but these are our limitations (Member of staff)

Table 21. Theme/Standard 5 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Infringement of life enjoyment; a life with significant limitations	**1,2,3**	
<u>Subthemes</u>		
Limited quality time and infringed rights	1,2,3	We organize sometimes some parties, for New Year's, birthday parties, summer day, which patients love. Some music and dancing for them here. Sometimes some patients go to the city and have some coffee, walk by the sea and come (Member of staff) We want to have as many patients who get discharged to be able to get some trades training and then work. It's challenging though, quite a bit as even places which may have some work, they won't hire our ex patients due to stigma. That's why we have a long way to go as a society (Member of staff) I have not been anywhere. I want to go out more often. I want to touch Vlora's sea water again….may be one day I will do so (Service user) I just want to return to my place once I feel better. No one else to share my room with there. I can smoke as much as I want and when I want. I don't have to take the siesta either. Ah, and I can sleep in my clothes, not hospital clothes (Service user) School was never her favourite activity to do. Just doing house chores, helping us as parents take care of all life obligations as cooking, is what we hope she will when she comes home. She will need to keep herself busy (Family member) Not many patients want to vote, unless it is a way of getting out of here, but we take them to centres to vote, if so. They don't part take in anything else of any political or social nature out there (Member of staff)

SECTION 2: "SADIK DINCI" ELBASAN PSYCHIATRIC HOSPITAL FINDINGS QualityRights Toolkit Theme/Standard 1: The right to an adequate standard of living and social protection

Theme/Standard 1 is comprised of the sub-standards captured in Table 22 below:

Table 22: Theme/Standard 1 Sub-standards

Theme/Standard 1: The right to an adequate standard of living and social protection						
S: 1.1 The building is in good physical condition	**S: 1.2** The sleeping conditions of service users are comfortable and allow sufficient privacy	**S: 1.3** The facility meets hygiene and sanitary requirements	**S: 1.4** Service users are given food, safe drinking-water and clothing that meet their needs and preferences	**S: 1.5** Service users can communicate freely, and their right to privacy is respected	**S: 1.6** The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction	**S: 1.7** Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

Tables below provides an overview of study participants' frequency of reported themes and descriptions of Theme/Standard 1 sub-standards.

Table 23. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	
Indecent living conditions, a dreadful reality <u>Subthemes:</u>	**1,2,3**	
Overcrowding, a daily reality across all units	1,2,3	There are eight other guys in my room. They all smoke, I don't, I mean I end up smoking their smoke, as they all smoke. It makes me sick….(Service user) Ten people in one room, I was much better off in my city…., I want to go back. It is all men, the majority of them are really mentally sick, they talk to themselves, even at night, I can't sleep because of them, I want some peace, and I can't find it here (Service user)

Inadequate living conditions across all inpatient units	1,2,3	Up to twelve patients in one room, on separate floors. This must change, I don't know when, it is too many altogether (Member of staff) I have everything in my bed, my sheets, the pillow, the blanket. They are alright for me (Service user) I am a bit cold in my room, now in winter, and I feel hot in summer, you know, even when we keep windows open….(Service user) We eat on the same floor, on stools, next to one another …(Service user)
Rundown rooms/washrooms/showers	1,2,3	I have seen the showers once, they look like prison showers, next to one another with just some broken dividers in between. They are all women, but still….. (Family member)
Safety concerns for staff and service users due to eruption of violence amongst service users	1,2,3	I don't know what to do if there is fire, I can't get out of the windows, because of the bars….staff would let us know, I know (Service user) The guys, here, fight sometimes. I don't start it……..(Service user) I doubt I will have any teeth left here, since I don't know when I will leave. There are violent men on this floor…..(Service user)

Table 24. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Lack of personal freedom and privacy <u>Subthemes:</u>	**1,2,3**	
Mandatory sleeping times	1,2,3	Come siesta time, and evening time, there has to be a schedule. There is too much chaos if they do not have these set times for bed as there are too many of them in one place (Member of staff) I get up and go to bed, when I am told, I follow directions, right? It's like being in the army. We also leave the room as a group (Service user) A lot of our routines are regimented, our new director has introduced a lot of strict control (Member of staff)
Mandatory hospital clothing	1,2,3	I kind of miss it, it has been years since I have been able to wear my home clothes. I miss home….(Service user) I've brought him his home clothes, but nurse will says he does not need them. Not sure why….(Family member)
Lack of service user privacy	1,2,3	Privacy is a word that does not apply to such places (Member of staff) I can't lock or secure anything that my mother brings me ….(Service user)
Limited communication on the part of service users	1,2,3	Only when I am here can I can see my child, otherwise we don't communicate until I come back. It is not the era of telegraphs, it should be easier to talk to each other. The hospital is so far behind. Maybe it benefits the hospital to be so cut off….(Family member)
Limited movement within and outside inpatient units	1,3	I like it when we are outside and not inside the buildings, I want to be out for longer periods of time though….(Service user) They want to spend a lot more time outside, but they can't as we don't have staff to accompany them (Member of staff)

Table 25. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Infringement of enjoyment of personal and social life, a significant life limitation	**1,2,3**	
<u>Subthemes:</u>		
Family abandonment	1,2,3	Only my mother comes to see me, nobody else (Service user)
		This is the place where people get forgotten, for the most part. No letters, no telephone calls, from what I know (Member of staff)
Limited enjoyment of outdoor activities	1,2,3	I like going to the recreation centre, now it is not allowed as much…..(Service user)
		I go by bus to different places: have a haircut, see some places, drink some coffee which is my favourite hobby. I want to go places more often….(Service user)
Limited enjoyment of indoor activities, with desirability for prolonged outdoor activitities	1,2,3	I like it when we are outside and not inside the building, there is nothing to do on our floor…. (Service user)
Stigma (Family member's)	2,3	I don't want my son to mingle with any women as he is sick. I want him to return home once he feels better and listens to the doctor's advice. (Family member)
		I guess staff find it difficult having so many crazy patients in one place (Family member)
		They no longer dress in the old ugly hospital uniforms, thank God, as they were awful. The current clothing they wear makes them look more human, thanks to the donors (Member of staff)

QualityRights Toolkit Theme/Standard 2: The right to enjoyment of the highest attainable standard of physical and mental health

Theme/Standard 2 is comprised of the sub-standards captured in Table 26 below:

Table 26. Theme/Standard 2 Sub-standards

Theme 2: The right to enjoyment of the highest attainable standard of physical and mental health				
S: 2.1 Facilities are Available to everyone who requires treatment and support	**S: 2.2** The facility has skilled staff and provides good-quality mental health services	**S: 2.3** Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community	**S: 2.4** Psychotropic medication is available, affordable and used appropriately	**S: 2.5** Adequate services are available for general and reproductive health

Tables below provides an overview of study participants' frequency of reported themes.

Table 27. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Easy access to hospital care, despite other service limitations <u>Subthemes:</u> Inclusion criteria as an access to care determining factor	**1,2,3** 1,2,3	No one is denied access to service providing they are old enough to be seen here, and have a mental diagnosis (Member of staff) My brother brought me here and staff kept me here. I told them and my brother I wanted to go back to my city….., but they said, I cannot because I was sick... (Service user) I am still here, and I don't want to be here, correct? I don't have a problem with getting my treatment here…..(Service user)

		No one wants to be here for the most part, nor do we want to keep patients who don't meet our inclusion criteria (Member of staff)
Compromised care due to staff shortage and lack of funding	2,3	They complain they have a staffing shortage though, which could be the case. Shouldn't the government do something about this? (Family member) We have 1 psychiatrist per 100 patients in this hospital, which is insufficient (Member of staff) …..recovery plans are not always complete, we have a long way to go….we do ask patients what they wish to do…but there is not enough time and staff to dedicate a lot of attention to one patient (Member of staff) I can't stay long outside….I want to… (Service user) …..not enough staff to be with more patients at the recreation centre (Member of staff)
Rapid access to physicians consults	1,2,3	I can speak to my doctor anytime I want (Service user) It takes a maximum of two days for the doctor to see a patient who asks for them (Member of staff)
Adequate supplies of free medication with partial education on side-effects	1,2,3	We have an approved list of medication and all medication on the list is available to us (Member of staff) I take the medication I am given, it's not much, I don't pay for it, no money… (Service user)
Partial health promotion activities	1,3	We offer general checkups ups every six (6) months, an initial checkup at the time of admission and on an as per need basis by doctor orders. Blood work is done once a month (Member of staff) ….I love smoking. I smoke every day. The nurse won't let me keep the whole pack, he gives me some cigarettes when I ask. I want the whole pack though…..(Service user)

Table 28. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
The medical model and patient institutionalization as the main treatment model	**1,2,3**	
<u>Subthemes:</u>		
Treatment with medication as determined by psychiatrists is the main form of treatment	2,3	……pharmacological treatment remains at the heart of the treatment plan (Member of staff) We try to make decisions as a team and see what is best for them though…i.e., they don't want to stay here, but they are ill, we have to help them get stabilized with medication…(Member of staff)
Partial psychosocial treatment available	1,2,3	We also have mixed gender group therapy with 6-10 patients per group….. (Member of staff)
Long standing history of crowded institutionalization of service users	1,3	……it is better than what it was years ago, yet, when people live in crowds like this it is inhumane. The government should find better solutions such as smaller hospitals where people don't stay institutionalized for years (Member of staff) …but there are so many patients and some of them are here for a few years (Family member)
Knowledgeable staff about limited community and recovery based resources	2,3	Connecting patients with community resources is a real challenge and there is not much available in Elbasan and peripheral cities. There is the community mental health centre in Elbasan, that's pretty much all that is available (Member of staff)

Table 29. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Lack of knowledge of CRPD and limited knowledge of service user rights	**1,2,3**	
<u>Subthemes:</u>		
Limited range of mechanisms for service users to express an opinion	1,2,3	I have never heard of CRPD myself. We have had some training on patient rights and there are professional codes of conduct expected through the licensing body of our professions in which we are to treat patients respectfully and provide the best care we can deliver (Member of staff) ……the advanced directives? I have never heard of it. I would like to see some examples of how it has worked elsewhere as I can't help but think how that could happen here with patients who get upset over nothing (Member of staff) ….staff will not let me speak to the director... I want to tell the director I want to leave. They must want to keep me here. (Service user)
Service users and family members depending on staff to know users' rights	1,2	Not sure I understand what my rights are, staff would know (Service user) …the medical staff would know… I would assume the meds are working (Family member)
Legacy of past isolation on understanding of human rights	2	Even if there was a lot of information on patient rights, I don't know if staff would so easily change. Lack of compassion regarding the vulnerable people is ingrained in our culture and change is hard when you have been isolated for so long (Family member)

Table 30. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Stigma, a quality of life deteriorating factor <u>Subthemes:</u>	**1,2,3**	
Internalized stigma	1	I don't want many people to know about me being sick, as when I get back home they will think poorly of me (Service user)
Stigma (staff's and family members')	2,3	Let's be realistic, an outing somewhere will not help the person recover the same way medication does. These are mentally sick people…(Member of staff) …advanced directives, I don't know what they are. They are not applied here. They don't get applied with normal people, let alone with psychiatric patients (Member of staff) I don't believe there is any cure for schizophrenic people (Family member)

Table 31. Theme 2 Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Staff dissatisfaction, a prevalent sentiment <u>Subthemes:</u>	**1,2,3**	
Staff lack of rights	3	I want to hear about a CRPD for staff, too, and what can be done to increase our salaries, which are ridiculous…(Member of staff)

Violence against staff	3	Patient's abuse patients and staff, and staff restrain them, it is better than what it was years ago, however, how is it humane to live in such a crowded situation. The government should find better solutions and smaller hospitals (Member of staff)
Staff fear of repercussions	3	I trust you will treat this information as you said you would, as I don't want to lose even this job. I have decided to answer your questions as you are not with the media and you are not recording this interview. It is quite difficult getting any jobs here……(Member of staff)

QualityRights Toolkit Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person

Theme/Standard 3 is comprised of the sub-standards captured in Table 32 below:

Table 32: Theme/Standard 3 Sub-standards

Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person			
S:3.1 Service users' preferences regarding the place and form of treatment are always a priority	**S:3.2** Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	**S: 3.3** Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	**S: 3.4** Service users have the right to confidentiality and access to their personal health information

Tables below provides an overview of study participants' frequency of reported themes.

Table 33. Theme/Standard 3 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Limited service user informed decision making, and its role in recovery	**1,2,3**	
<u>Subthemes:</u>		
A top-down approach to access to care	1,2,3	……patients have no say which hospital they go to, it is predetermined by the structure of the health system, Elbasan residents and the surroundings get treated in Elbasan hospitals. If a mentally sick family member is not wanted in their home and there is nowhere to send them to in the community, they stay here (Member of staff)
Member of staff (psychiatrists), with limited input from family members determine course of treatments	1,2,3	It is usually the family members, if they have any that speak with the team here who decide what is best for them. If this is called substitute decision making, then that is what we practice here (Member of staff)

Limited community infrastructure does not facilitate de-hospitalization of service users	1,2,3	Not every family member wants them home though. We have no choice but to act on a per client case and keep them here if there is no other place to send them to. There is just one supported house in Cerrik for such patients and it is always full (Member of staff)
Lack of formal procedures and processes to support service users' understanding of their rights	1,2,3	We don't go over any patient rights information with patients (Member of staff) Nobody has given me anything about my rights, I must know something though (Service user)
Stigma on the part of staff	2,3	….mental health treatment in inpatient units is different from other health specialties, where patients can leave the hospital and have a lot more say in their treatment, etc. (Member of staff) This is a psychiatric hospital where people are sick and cannot often be taken seriously for what they say as it could be something they say because they are sick (Member of staff)
Limited external support network in decision making	1,3	There are no people in the community who would speak for service users rights (Member of staff)

Table 34. Theme/Standard 3 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Themes **Present yet controversial legal and procedural guidelines regarding voluntary and involuntary admissions** <u>Subthemes:</u>	**1,2,3**	
Admissions criteria exist for involuntary admissions	1,3	The old way of practicing, up until a few years ago, did not require any patient consent for admittance. We give them 48 hours to sign the papers, if not, we follow legal procedures and alert the district court

		who in turn sends its representatives to assess the patients mental state (Member of staff)
Ambiguously compliant admissions practices	1,2,3	Lots of patients when they arrive don't want to sign the file, I mean, consent to being here. They usually sign it within two days. I am not sure if patients refusing treatment in such a place is possible, let alone appealing the decision (Member of staff)
Lack of information on the part of service users regarding appeals procedures and legal representation	1,3	There are no appeal procedures and no legal representation that patients are informed about. Whatever the court determines, we do (Member of staff) I know I don't want to be here, I don't know anyone to get me out of here. Are you a lawyer – can you get me out of here? I need a lawyer but don't know where to find one (Service user)
Confidential files for service users exist but access by members of staff only	1,2,3	Only staff have access to such files. I find it inappropriate for patients to access files….never heard of it before (Member of staff)

QualityRights Toolkit Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, or punishment from exploitation, violence and abuse

Theme/Standard 4 is comprised of the sub-standards captured in Table 35 below:

Table 35: Theme/Standard 4 Sub-standards

Theme 4: Freedom from torture, cruel inhumane or degrading treatment, or punishment from exploitation, violence and abuse				
S: 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect	**S: 4.2** Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	**S: 4.3** Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user	**S: 4.4** No service user is subjected to medical or scientific experimentation without his or her informed consent	**S: 4.5** Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse

Tables below provides an overview of study participants' frequency of reported themes.

Table 36. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Contradictory attitude towards service users on the part of staff, with impact on service user recovery <u>Subthemes:</u>	**1,2,3**	
Compassionate as well as verbally disrespectful attitude on the part of staff	1,2	I see the psychologist, I like her a lot, she gathers us in a group….. (Service user) Not very kind people at the emergency room. They pushed me and kept me here.

		I don't want to be here, they kept me here (Service user)
Presence of policy against service user abuse	1,3	My roommates bother me, sometimes. They start fights, the staff protects me sometimes, when they can, they get hit, too. I have never been hit by staff, when they get upset because of the fights, they yell though, we all, do… (Service user) We have a policy about treating patients professionally, but that is it (Member of staff) I know some information about how patients should be treated, it is the expectation of our funder. I have some training on this topic as we have a policy for this purpose (Member of staff)
Lack of information on service user maltreatment	3	I don't know of any abuse cases. It does not mean they have not happened. In the former system for sure. The current director is very strict with us and the hospital, trying to improve the services here. We're all expected to do nothing but the very best (Member of staff)
Patient to patient violence	1,2,3	…..my teeth are not good, some are missing and some are loose (Service user)

Table 37. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Mixed restraint forms of service users <u>Subthemes:</u>	**1,2,3**	
Chemical restraints, in the absence of seclusion rooms, as a response to inadequate de-escalation procedures Physical restraints, in the absence of seclusion rooms, as a response to	1,2,3	We have not had a seclusion room for ages. Patients who are very agitated get either chemically or physically restrained at the ER room, and are tied to their bed as per doctor's advice. We don't have to report such cases anywhere. In my view de-escalation strategies don't work when patients are very agitated (Member of staff)

inadequate de-escalation procedures	1,3	We restrain patients who are being violent towards others……. We have no choice, my experience has been that no matter how well you may know the triggers of a patient, including the patient
Compliant restraint processes with restraint guidelines	3	himself/herself, they will pick up a fight (Member of staff) Everything gets documented on the patient chart, and gets reported to the hospital directors. The doctor tells us how long to restrain for, etc. (Member of staff)
Stigma (staff's)	3	The personal support workers hold them so that patient agitation is not increasing…...the restraint experience is recorded, i.e., duration on patient charts (Member of staff)
No ECT use and/or medical experimentation	3	In my view de-escalation strategies don't work when they (service users) are very agitated (Member of staff) Since 1988 we don't offer any ECT (Member of staff)

Table 38. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Fragmented monitoring mechanisms of service users rights <u>Subthemes:</u>	**1,2,3**	
Limited presence of an independent body	1,3	The Ombudsman's office visits us (Member of staff)
Lack of legal representation/service user advocates	1,2,3	I think it is the trend everywhere these days where staff are video recorded secretly to expose any abuse towards patients (Member of staff) I don't know of any other people, or what you call: service user advocates who come to visit (Member of staff)

Limited access of service users to complaint mechanisms	1,3	No process for patients to complain formally (Member of staff) I think they are holding me here wrongfully as I want to leave and they don't let me speak to the director, or use any phones either. I want to call my sisters to get me out of here (Service user) We don't have any mechanisms to inform patients where to complain or file appeals…..At times, family members speak to the director directly (Member of staff)
No disclosure of data on service users abuse/neglect and/or any disciplinary action against any person with history of service user abuse/neglect	3	I don't have any information on cases of abuse against patients, can't comment any further (Member of staff)

QualityRights Rights Theme/Standard 5: The right to live independently and be included in the community

Theme/Standard 5 is comprised of the sub-standards captured in Table 39 below:

Table 39. Theme/Standard 5 Sub-standards

Theme 5: The right to live independently and be included in the community			
S: 5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community	**5.2** Service users can access education and employment opportunities	**S: 5.3** The right of service users to participate in political and public life and to exercise freedom of association is supported	**S: 5.4** Service users are supported in taking part in social, cultural, religious and leisure activities

Tables below provides an overview of study participants' frequency of reported themes.

Table 40. Theme/Standard 5 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Serious lack of community infrastructure to support de-institutionalization	**1,2,3**	
<u>Subthemes</u>		
Lack of housing for people with mental disorders	1,3	Serious lack of community housing. This is Elbasan, not some place in the Western world where people without homes and families have places to go to (Member of staff)
Lack of community resources to respond to treatment needs in case of deinstitutionalized patients	1,2,3	I will be here, this is my home, nowhere else to go to (Service user) You must have heard of the case of that man with past psychiatric history who beheaded his teenage nephew. He was let free without any monitoring on the part of medical staff in the community (Member of staff)

Table 41. Theme/Standard 5 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Lack of resources, a serious limiting factor	**2,3**	
<u>Subthemes</u>		
Lack of hospital resources	1,2,3	I went with other people here on a trip to Cerrik. I liked the house there. If I was always sick, which I don't think I will be, I would like to be there, I can go out, but staff say there is not room for new guys there… not so many guys who talk to themselves there…..(Service user) I want to go on more excursions. I want to be in the city more often….. Elbasan is a nice city…I like the castle (Service user). I want to use the computer too, but it does not work (Service user) Almost everyone wants to go out on mini buses, have some coffee in town, go sightseeing, it's not possible …….never enough staff to do frequent outings (Member of staff)
Lack of funding	3	My complain is about the government who took pension of such ill people away when they are in hospitals, and when they have no surviving family members, what laws are these? (Family member)

Table 42. Theme/Standard 5 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Stigma, and its impact <u>Subthemes</u>	**2,3**	
Stigma on the part of staff	3	If only we could accommodate patients in the community, some would have to live in locked places though as a few of them are not well to be let free. You must have heard of the case of that man with past psychiatric history who beheaded his teenage nephew. He was let free without any monitoring on the part of medical staff in the community (Member of staff) There is a lot of unemployment for normal people, that's why they immigrate. How can there be work for these sick patients? Schooling is a different story, these days you pay the money and get schooled….(Member of staff)
Stigma on the part of family members	2	My son is expected to come home, once he feels more normal than what he was since he was sick….. (Family member) They (service user) cannot do any other basic stuff others can (Family member)

Table 43. Theme/Standard 5 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	Study Group Reporting Theme	Illustrative Quotations
Infringement of enjoyment of life	**1,2,3**	
<u>Subthemes</u>		I like going on excursions with others and staff, on buses. I like it a lot. No windows with bars on buses….(Service user)
Limited quality time and infringed rights	1,2,3	I know we eat some good food for New Year's and get some new clothes. I need some new clothes. I will see what I will get this year (Service user)
		No one vote here. We try to keep politics out of here. Some long term patients ended up here because of being political dissidents, it cost their life…. (Member of staff)
		….and I like having Turkish coffee, it goes well with the cigarettes (Service user)
		I don't vote, I see people voting on TV… (Service user)
		These are places where the word 'life enjoyment' does not apply. We don't care about him voting. We just want him to get better and return home (Family member)
		As long as my sister has her basic needs met, spends some time outside, if possible one day she shares a room with fewer people, she is ok. It is insane looking at the windows with bars on them, and patients spitting out of them, waving hands, etc…… (Family member)
		We don't tell them about any concerts in the city as they won't be able to attend, anyways (Member of staff)
		Just live and breathe is this place about. Only those patients who family members take them home for few days, see something different, and the ones going out from time to time (Member of staff)
		I think I do a good job as a mechanic. I help out here, I don't get paid though, that's ok, I do it because I want to (Service user)

SECTION 3: VLORA REGIONAL HOSPITAL SURGERY UNIT FINDINGS

QualityRights Toolkit Theme/Standard 1: The right to an adequate standard of living and social protection

All theme questions were modified to reflect the service provided in a surgery unit: physical versus mental health services.

Theme/Standard 1 is comprised of the sub-standards captured in Table 44 below:

Table 44: Theme/Standard 1 Qualitative Data Findings

Theme/Standard 1: The right to an adequate standard of living and social protection						
S: 1.1 The building is in good physical condition	**S: 1.2** The sleeping conditions of service users are comfortable and allow sufficient privacy	**S: 1.3** The facility meets hygiene and sanitary requirements	**S: 1.4** Service users are given food, safe drinking-water and clothing that meets their needs and preferences	**S: 1.5** Service users can communicate freely, and their right to privacy is respected	**S: 1.6** The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction	**S: 1.7** Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

Tables below provides an overview of study participants' frequency of reported themes.

Table 44. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Physical improvements of the hospital conducive to service user needs despite their limitations <u>Subthemes:</u>	**1, 2, 3**	
Post '90s renovations to address service gaps with limitations and caregiving implications for family members	1,2,3	It's not as warm in the room though, maybe because patients should not be as warm in here (Family member) My bed is not bad, so is my room. Lots of lighting from the windows which I don't like as I want some curtains to block the light, it bothers me (Service user)

		Best state of this building since its construction. New windows, painted walls, clean sheets, etc, etc. We have two elevators, a ramp, all patients with disabilities are accommodated. We don't have any measures, other than a fire extinguisher, against fire. No sprinkler system either. I don't know if we have any policies on dealing with fires (Member of staff)
Unit damage by family compromises service user quality of care	3	Patients have access to showers, however they are not very functional as often times the shower heads go missing. We replaced a shower head twice, and twice it was stolen (Member of staff)
Privacy improvements allow for more comfort amongst inpatients	1,2,3	If we don't have too many patients operated in any given day, then we have patient rooms with fewer patients, 1 or max 2, which patients and their family members prefer a lot (Member of staff)

Table 45. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Service users freedom and the supportive role of their family members as key factors in the service user recovery process	**1,2,3**	
<u>Subthemes:</u> Service user freedoms (movement with physical limitations, communication, choice of life essentials) contribute to quality of hospitalization	1,2,3	We've brought our own blankets and sheets from home, but the hospital provides its own sheets, etc. for those who want them and they seem good from what I see (Family member) My wife cooks for me, my relatives bring some food, too. I am lucky to have relatives be with me. Not everyone has family members look after them. You can tell I am wearing my clothes, not hospital's. Thank God for this era when we don't have to look like orphans or imprisoned… which we all had to wear the same stripy uniforms once upon a time (Service user)
Family members as key players in service user recovery process	1,2,3	You saw for yourselves, every room is full of family members. One good thing we have, us Albanians, we're always there for the person who is sick, sometimes too much. And no one respects the visiting hrs, which makes out job more difficult ……(Member of staff)

QualityRights Toolkit Theme/Standard 2: The right to enjoyment of the highest attainable standard of physical and mental health

Theme/Standard 2 is comprised of the sub-standards captured in the Table 46 below:

Table 46: Theme/Standard 2 Sub-standards

Theme/Standard 2: The right to enjoyment of the highest attainable standard of physical and mental health				
S: 2.1 Facilities are Available to everyone who requires treatment and support	**S: 2.2** The facility has skilled staff and provides good-quality mental health services	**S: 2.3** Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community	**S: 2.4** Psychotropic medication is available, affordable and used appropriately	**S: 2.5** Adequate services are available for general and reproductive health

Tables below provides an overview of study participants' frequency of reported themes.

Table 47. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Pathways and challenges in order to access hospital care <u>Subthemes:</u>	**1,2,3**	
Family physician referrals and emergency service as points of admission to surgery unit	1,2,3	I came here because my family doctor sent me here, and the hospital said 'ok' to me getting hospitalized for (Service user) We admit patients referred from: Emergency room, Family Physician, District Surgeon/specialist. We see anyone of 0+ years of age. We have not rejected any patients who needed service (Member of staff)
Surgeons extorting schemes as barriers to access to care	1,2	Look, you ask whether I received help when I asked for and whether I am getting treated, by the medical personnel. When

		you pay, you get treated. Doctors are great at saving lives, great at milking too….you can't get help unless the doctor is happy…..and if the doctor is not happy, nothing good comes out of it. I want to get better and return to my little place. Payment should not be a condition of getting operated. It is not fair since this is a public hospital. If I had the money, I would have gone to the German or the American hospital in Tirana. That's it (Service user)
Staff attitude valued in service user recovery	3	We came through the emergency department…we could not end up in this unit without paying the doctor in emergency unit. I won't tell you how much he asked for, but we had to pay to get service (Family member)
Comprehensive examination and care once admitted	1,2,3	I am happy with staff who has seen me here, including the cleaners who are not lazy and keep my room and washroom clean (Service user) Yes, this one I know about, my relative said he had to have a few tests done, and then have the surgery go ahead with (Family member)
Medication availability meets service user needs	1,2,3	At least we have not paid for the hospital medication (Family member)
Physicians, as key determinants of patient treatment process	1,2,3	We have an approved list of medication used in the hospital. It is generic not brand though. Some family members bring brand medication for their loved ones though. We have been so lucky to have no shortage of meds, up until sometime ago, patients would go and buy some missing meds from pharmacies (Member of staff) At least the medication is provided by the hospital. Don't get me wrong, it is not brand medication. I hope it is not expired medication which we have by now become so famous for: Albania, the country with expired medication dispensed in pharmacies whose expired medication is subsidized by the government (Family member)

		We're very compliant with doctors directions when it comes to things that have to do with surgery knives…..no one wants to have any infections after surgeries, as we often hear people end up after leaving hospitals. So, I'd say we're doing what the doctor says (Family member)

Table 48. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Limited awareness of service user human rights despite anti-corruption and service quality improvement efforts on the part of the government	**1,2,3**	
<u>Subthemes:</u>		
Limited knowledge of patient rights including limited service user feedback solicitation practices	1,2,3	Nobody said anything about patient rights. You tell me what they are….(Service user)
Anti-corruption and service quality improvement efforts on the part of the government	2,3	Doctors know best what people need, as long as they don't send people everywhere to undergo medical test for the sake of people wasting their money in labs, paying other doctors, etc. Thank you Edi Rama for trying to fight corruption (Service user)

Table 49. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Staff dissatisfaction	**1,2,3**	
<u>Subthemes:</u>		
Staff rights infringement and violence against staff	3	……I said it is us getting abused by family members. Nurses try to convince them all is done as it should, but they are so short tempered often, eg, they demand brand medication for their loved one, which we don't have. They need to speak to the government about that, not us (Staff)
Staff fear of being watched	3	Those who are really upset by what they see happening, tend these days to collaborate with media to expose corruption, i.e., using secret cameras, cell phones, etc. as they need proof to prove (Staff)

QualityRights Toolkit Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person

Theme/Standard 3 is comprised of the sub-standards captured in Table 50 below:

Table 50: Theme/Standard 3 Sub-standards

Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person			
S:3.1 Service users' preferences regarding the place and form of treatment are always a priority	**S:3.2** Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	**S: 3.3** Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	**S: 3.4** Service users have the right to confidentiality and access to their personal health information

Tables below provides an overview of study participants' frequency of reported themes.

Table 51. Theme/Standard 3 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Limitations to service users' decision making freedom <u>Subthemes:</u> Limited formal procedures and processes to support service users understanding of their rights and the voluntary nature of their admission	**1,2,3** 1,2,3	I signed some papers but don't remember exactly what they were. Kind of agreeing to anything that could happen to me. This is a different era we live in, saying 'yes' to anything that may go wrong…..(Service user) The surgeon who operated on me, spoke in plain Albanian what he had to do. I am a man, I can handle a surgery. The nurses come and go day and night, check on me, if I have any fever, how my wound is recovering. I want to think I am in good hands (Service user)

Service user discharge promoted	2,3	I don't believe staff would stretch someone's stay here longer than needed. Usually, what I hear from friends is getting here that gets stretched, or having all kinds of tests to pay private labs etc, prior to coming here that happens (Family member)

Table 52. Theme/Standard 3 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Themes		
Limited application of service users right to confidentiality with no service user access to their medical file	**1,2,3**	
<u>Subthemes:</u>		
Mixed attitudes on the part of staff	1,3	I was not alone when the doctor spoke. Both myself and my family were with me. Doctors don't complicate things for old people. Together with nurses they say what they need to do and I understood that for what an old person can understand (Service user)
Access to medical files by staff only	1,3	I don't know where doctors keep their notes about us all. I don't really care to know (Service user)

QualityRights Toolkit Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, punishment from exploitation, violence and abuse

Theme/Standard 4 is comprised of the sub-standards captured in Table 53 below:

Table 53: Theme/Standard 4 Sub-standards

Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, punishment from exploitation, violence and abuse				
S: 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect	**S: 4.2** Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	**S: 4.3** Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user	**S: 4.4** No service user is subjected to medical or scientific experimentation without his or her informed consent	**S: 4.5** Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse

Table 54. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Medical professional staff attitude as responsive <u>Subthemes:</u>	**1,2,3**	
The governmental effort on fighting system abuse has medical staff responsive to service users and family members requests	1,2	As for mechanisms of expressing feedback, there are posters on walls in the main area which encourage patients to denounce corruption: receiving money from patients in order to access services (Member of staff)

Table 55. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	Study Group Reporting Theme	Illustrative Quotations
Limited client feedback soliciting procedures	**1,2,3**	
<u>Subtheme</u>		
Pathways to providing feedback	1,3	
Staff training needs	3	We don't restrain any patients. Only the ones who need our service and need to be here, are here. We've had some training on how to engage with clients who are agitated, and sometimes it works. But I feel we need new training, ongoing training and help (Staff)
Informality and privilege	3	The emergency department is the worst place for ripping off families. I wish I was able to record the conversation that went on there and send it to 'Fiksi' after my husband would have left this hospital. It is a shame as the prime minister talks everywhere about stopping corruption in health care. This is public hospital, not a private one. I guess, it is normal to rip off patients, as that's what happens in this country, the rich rip off the poor. Numerous scandals on TV about corruption, and some suffer the consequences of what they do, and some don't, which means that again, you may end up interacting with that person in the health care system (Family Member)
Trust and mistrust on mechanisms to offer feedback	1,2,3	
The end result of medical intervention determines if there is feedback initiation	1,2	

Table 56. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	Study Group Reporting Theme	Illustrative Quotations
Partial promotion of service users rights and lack of staff rights involve abuse on both sides	**1,2,3**	
<u>Subthemes</u>		
Perceived and real service user abuse/neglect produces staff abuse	1,2,3	…….often we're treated poorly. A family member became upset because I asked him to not make the floor dirty otherwise others would fall and this is the surgery unit. He kicked the bucket with water and spread it all over the floor. What could I say? I said nothing as he could have punched me as well. I cannot remember the times family members have pushed, or grabbed staff, including doctors and nurses. No protection whatsoever for us.
Limited staff training on service users rights	1,3	Don't ask me such questions please, I don't know what all patient rights are……(Member of staff)
Lack of posted staff rights	3	Nothing posted anywhere anything about our rights. That's why we get abused (Member of staff)

QualityRights Theme 5: The right to live independently and be included in the community questions were not administered with the Vlora General Hospital given that these questions did not apply to this setting.

SECTION 4: ELBASAN REGIONAL HOSPITAL SURGERY UNIT FINDINGS

QualityRights Toolkit Theme/Standard 1: The right to an adequate standard of living and social protection

Theme/Standard 1 is comprised of the sub-standards captured in Table 57 below:

Table 57: Theme/Standard 1 Sub-standards

Theme/Standard 1: The right to an adequate standard of living and social protection						
S: 1.1 The building is in good physical condition	**S: 1.2** The sleeping conditions of service users are comfortable and allow sufficient privacy	**S: 1.3** The facility meets hygiene and sanitary requirements	**S: 1.4** Service users are given food, safe drinking-water and clothing that meets their needs and preferences	**S: 1.5** Service users can communicate freely, and their right to privacy is respected	**S: 1.6** The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction	**S: 1.7** Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

Tables below provides an overview of study participants' frequency of reported themes.

Table 58. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Improved hospital environment and atmosphere yet not contemporarily compatible <u>Subthemes:</u> Newly erected hospital and unit with limitations	**1, 2, 3** 1,2,3	…..the best improvement here is the ensuite washroom…(Service user) One complaint, when these walls were built…, couldn't the builder do a better job at ensuring that plumbing and plastering is well done? No need for mould in a newly built hospital (Service user)

		The only complaint I have is the lack of privacy curtains, they exist, even in Albania, at hospital 'Nene Tereza' in Tirana (Service user) Too bad there is no bed panel which alerts nurses on the patient's condition, as they exist abroad, Germany for example. No harm done if there was a TV as well; trying to get a patients mind off surgery (Family member)
Minimized room occupancy different from past history	1,2,3	I have to share the room with two other guys, I knew this, it's a hospital, I have had friends in hospital, and they all shared rooms…. (Service user) Just 2-3 people in one room, which is good, at least here we've improved since Enver's time (Family member)
Freedom to choose and preference of home based essentials despite presence of hospital supplies	1,2,3	My parents made sure I have my bedsheets and blanket and pillow from home. I am glad the hospital allows it. I don't keep anything here other than the food my family brings here (Service user) It goes without saying my pyjamas are mine (Service user) Food is good too, the pureed food is good, and so are the soups, but they prefer food from home (Family member)

Table 59. Theme/Standard 1 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Service users freedom as well as the supportive role in of their family members as key factors in their recovery process	**1,2,3**	
<u>Subthemes:</u> Freedom of movement limited by physical limitation, as well as limited privacy, with freedom to communicate intact	1,2,3	Movement within the floor is the only activity allowed due to surgery. Please bear in mind that surgery is an invasive procedure and patients need time to recuperate and not engage in strenuous activities, socializing being one of them (Family member)

Family members as key players in service user recovery process	1,2,3	It would have been best if I had some privacy at times, but I won't be here forever anyways…. (Service user) I stay here for the most part, helping him with anything that he asks for, and then other relatives and the children come and help. We take turns. He is the man of the house and we need him to be healthy and strong (Family member) We have visiting hours that family members don't adhere to as all patients have family members caring for them here, it's the typical Albanian way of supporting the sick family member (Family member) My relatives know better about my health than I do. They have been speaking to the doctor and nurses. I trust them and will let them deal with everything. As they say, all I have to do, is get better and rest (Service user)

QualityRights Toolkit Theme/Standard 2: The right to enjoyment of the highest attainable standard of physical and mental health

Theme/Standard 2 is comprised of the sub-standards captured Table 60 below:

Table 60: Theme/Standard 2 Sub-standards

Theme/Standard 2: The right to enjoyment of the highest attainable standard of physical and mental health				
S: 2.1 Facilities are Available to everyone who requires treatment and support	**S: 2.2** The facility has skilled staff and provides good-quality mental health services	**S: 2.3** Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community	**S: 2.4** Psychotropic medication is available, affordable and used appropriately	**S: 2.5** Adequate services are available for general and reproductive health

Tables below provides an overview of study participants' frequency of reported themes.

Table 61. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Theme	**Study Group Reporting Theme**	**Illustrative Quotations**
Pathways and challenges in order to access hospital care <u>Subthemes:</u>	**1,2,3**	
Family physician referrals and emergency service as point of admission to surgery unit	1,2,3	We deny services only when patients don't meet our criteria. We see patients sent from their family physicians, which are planned interventions, the emergency room, and the district specialist (Member of staff)
Quality of care contingent upon staff expertise/experience and willingness to serve well	2,3	What you see on TV where the family member beats up the surgeon because the surgeon does not admit his wife to hospital, did not happen to me (Service user)

Comprehensive examination and care once admitted	1,2,3	We have … surgeons,…plastic surgeons for burns, urologist, ….nurses…Our doctors go back a long way, they are very experienced, some of the best that are out there… (Staff) The doctor speaks to me every morning and the nurses are quite good (Service user) All staff seem well qualified, a few of them have worked here since the tough communist regime, which means they are good, if they are willing to do their best….. (Family member)
Lack of hospital medication a barrier to recovery and a financial burden to patient family	1,2	I don't want to ever have a surgery myself, but if I ever do, I'd know that I would have every test needed done., similar to what my husband had (Family member) One big complaint, paying for my own meds here, the IV, unacceptable. I hope the Prime Minister knows about it after we get treated…..(Service user) It has been a while since we have had all the meds. This was not the case years ago. The only thing missing is the IV mechanism (Member of staff) This problem should have ended a long time ago. I believe it is the hospital director's fault for having a shortage of medication here. What do hospitals in other cities have? We're tired of money profiting schemes from Albanians who use public hospitals, either the medication is not available and we have to get it from the pharmacy, or the food was of poor quality and the service was privatized, etc, etc (Family member) …..if state hospitals are declared a 'no pay zone' by Edi (the Prime Minister), then, they should remain as such (Service user)
Physicians, as key determinants of patient treatment process	1,2,3	When people come here, their choices are limited. They are here for the surgery and we follow the surgeon's recommendations. We try to get them back on their feet and then discharged (Staff)

		My doctor did the right thing, he said I needed surgery, and here I am. I just want it all to go as it should be (Service user) Often times the doctor's advice bears a lot more weight in young people (Family member)

Table 62. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Anti-corruption efforts of government aim to protect service user rights <u>Subthemes:</u>	**1,2,3**	
Limited knowledge of patient rights including limited service user feedback solicitation practices	1,2,3	You ask about patient rights and CRPD, we have policies on treating patients and have had some seminars on them. Never heard of CRPD though. It seems as if it has been there for few years (Member of staff)
Intensified government efforts to increase patient protection in health care affects staff performance	2,3	We do have a box of satisfaction surveys and flyers which patients and family members can complete. Flyers are provided by the funder. Nobody completes them…people don't want to leave papers behind (Member of staff)
Past system influences, along with expectations about staff knowledge of such rights	2,3	We're all so sensitized by what is happening with the 'denounce corruption' campaign undertaken by the government… (Member of staff) We're old people and did not grow up talking about rights. The system knew our rights, the doctors in this case. As long as they do their job (Family member) ….there must be some rights for us. I guess staff must tell us about them, if they know. If they don't, they should know so that we're told too (Service user) In the old system, we all knew where we stood in relation to the socialist state, out of fear of course, in this era we are struggling so much to find where we stand in relation to one-another. We are all Albanians yet

		we've been so 'hungry' for freedom that we're violating each other's boundaries except for those who realized that they were better off away from here. (Service user)

Table 63. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Moderate knowledge of service user rights <u>Subthemes:</u>	**3**	
Lack of knowledge of CRPD	3	You ask about patient rights and CRPD, we have policies on treating patients, have had some seminars on them. Never heard of CRPD though. It seems it has been there for few years (Member of staff)
Knowledge of service users rights to care, being free of abuse	3	We don't have a list of patient rights to provide them with, but if there was a third party, neutral, not medical staff who could inform them of their options, perhaps they would calm down and also learn to not abuse us. We are inspected regularly by our funder's local office, as well as main office in Tirana (Member of staff)
Limited range of mechanisms for service users to express an opinion	3	We do have a box of satisfaction surveys and flyers which patients and family members can complete. Flyers are provided by the funder. Nobody completes them…people don't want to leave papers behind. I too, though, you may have been part of a crew of people trying to video tape us and see what you can expose. It is not easy to work under these circumstances (Member of staff)

Table 64. Theme/Standard 2 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	Study Group Reporting Theme	Illustrative Quotations
Staff dissatisfaction <u>Subthemes:</u>	**3**	
Staff rights infringement and violence against staff	3	We work in difficult conditions, no protection, no security guards to protect us when we need them. We are at the mercy of anyone who comes and gets treatment here. Patients and family members compare this health care system against the one in a dictatorship. They say medical staff now does not care the same as in the other system because medical staff was afraid of making mistakes and suffering consequences. Now, the fear amongst us is bigger as there are times when we fear for our life on one hand, and on the other hand, the fear of getting fired by the hospital management team, if patient complains. While there are policies about how to treat patients, there are no policies on how to protect us (Member of staff) ….it is now known as 'white shirt abuse' in Albanian society, medical staff get punched, pushed, grabbed and have even had guns pointed at their head, if family members doesn't get what they need for their loved ones. The phenomenon began in chaotic 1997 and continues until now (Member of staff)
Staff fear of being watched	3	We're constantly watched….we're protecting our job as anyone can videotape anything, and send it to the media. I get people are tired of paying physicians primarily in exchange for services. Now all of us have to pay the price of being watched, videotaped and exposed in the media about anything that the patient does not feel is right….(Member of staff)

QualityRights Toolkit Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person

Theme/Standard 3 is comprised of the Sub-standards captured in Table below:

Table 65: Theme/Standard 3 Sub-standards

Theme/Standard 3: The right to exercise legal capacity and the right to personal freedom and the security of person			
S:3.1 Service users' preferences regarding the place and form of treatment are always a priority	**S:3.2** Procedures and safeguards are in place to prevent detention and treatment without free and informed consent	**S: 3.3** Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity	**S: 3.4** Service users have the right to confidentiality and access to their personal health information

Tables below provides an overview of study participants' frequency of reported themes.

Table 66. Theme/Standard 3 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Contradictory decision making freedom on the part of service users <u>Subthemes:</u>	**1,2,3**	
Recovery approach as an interactive process between medical staff and family members as informal substitute decision makers, despite service users provision of informed consent	1,2,3	Patients who come here and are treated are made fully aware of their situation from a medical standpoint, and then doctors take the lead in the treatment plan (Member of staff) I do feel that I was listened to, let's see the end result. As the proverb says: 'the result matters the most' (Service user) I know it is all about me, and that's why my family members are here with me. They talk to the doctor about my care, they understand things better than me, I am getting old you see. Like everyone else, I want to go home once my stiches are not that wet anymore (Service user)

Limited formal procedures and processes to support service users understanding of their rights and the voluntary nature of their admission	1,2,3	We don't have a list of patient rights to provide them with, but if there was a neutral third party, not medical staff who could inform them of their options, perhaps they would calm down and also learn to not abuse us (Member of staff)

Table 67. Theme/Standard 3 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Limited application of service users right to confidentiality with no service user access to their medical file	**1,2,3**	
<u>Subthemes:</u>		
Context based confidentiality	1,3	Well, all staff know which patient is in what room, they don't whisper who that person is and what he or she is here for….how can you keep the information so quiet when patients share rooms as well? (Member of staff)
Access to medical files by staff only	3	I have never heard of patients having access to their file, it is against the law. It is safer to be against the right to accessing the file than against the law (Member of staff)
Stigma on the part of staff	3	As for patient rights, we don't provide anything. Curious to know how a patient from Elbasan villages would comprehend the topic of patient rights if written material was to be provided to him or her and what's written on his file, if he was to access the file…(Member of staff)

QualityRights Toolkit Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, punishment from exploitation, violence and abuse

Theme/Standard 4 is comprised of the sub-standards captured in Table 68 below:

Table 68: Theme/Standard 4 Sub-standards

Theme/Standard 4: Freedom from torture, cruel inhumane or degrading treatment, punishment from exploitation, violence and abuse				
S: 4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect	**S: 4.2** Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises	**S: 4.3** Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user	**S: 4.4** No service user is subjected to medical or scientific experimentation without his or her informed consent	**S: 4.5** Safeguards are in place to prevent torture or cruel, inhuman or degrading treatment and other forms of ill-treatment and abuse

Tables below provides an overview of study participants' frequency of reported themes.

Table 69. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Medical professional staff attitude as responsive <u>Subthemes:</u> The governmental effort on fighting system abuse has medical staff responsive to service users and family members requests	**1,2,3** 1,2	Staff have been good to us, I don't need to ask about anything else (Service user) I have nothing to hide, I have been treated decently…. (Service user) I am pleased with how nurses in particular have treated me. It seems like there are

		two chief nurses, they are both great, the male and the female. They ask genuine questions, offer help, ask other nurses to help out. They must be protecting their jobs for sure as the government and people are targeting the corruption that exists in our health care system…….The government should have been tougher on corruption before…..(Service user)

Table 70. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	**Study Group Reporting Theme**	**Illustrative Quotations**
Limited client feedback soliciting procedures	**1,2,3**	
<u>Subtheme</u>		
Pathways to providing feedback	1,3	As a matter of fact no one mentions complaining etc. Actually, there is always something to not be 100% pleased about, whether it is food, or the blanket is too thick, too thin… bottom line is if I did not recover well, my parents would do something about it, I don't know what they would do, but they would… (Service user) There is a poster downstairs on denouncing corruption. It does not speak of denouncing incompetency, if that occurs. Edi should focus on holding staff accountable, competency wise, even though he asked them all to take competency tests…..(Service user) I don't know what the most effective method of reporting a complaint is, as doctors are above hospital directors often, no one can force them to do something they don't want, unless someone video records what they do wrong and sends it to the media (Service user)
Informality and privilege	3	As the expression says: "Do in Rome as the Romans do", we in this place resolve things often by talking to the right people on the side…..based on friendships and connections. Formal processes

		don't work the same way informality and connections work…..(Member of staff)
Trust and mistrust on mechanisms to offer feedback	1,2,3	I would not be talking to you, or maybe I would be talking you if I was treated badly, as I thought initially you may be here on a mission to see what happens in hospitals, right? My family members would know best what to do. It is the trend these days, everyone does business in hidden ways (Service user) Even, if I wanted to complain, as Edi R. says, where is the proof? It's not always possible to get the proof you need… (Service user) For as long as someone is still receiving care in a hospital, it is not wise to complain ……unless it is a life and death situation….. (Service user) People can talk directly to the chief surgeon, or the director of the hospital, or the chief nurse (Member of staff)
The end result of medical intervention determines if there is feedback initiation	1,2	So far, so good. The end result will speak for itself and if there is anything that needs to be said out loud about it (Service user)

Table 71. Theme/Standard 4 Qualitative Data Findings
Study participants: 1. Service Users; 2. Family Members; 3. Staff

Themes	Study Group Reporting Theme	Illustrative Quotations
Partial promotion of service users rights and lack of staff rights involve abuse on both sides	**1,2,3**	
<u>Subthemes</u>		
Perceived and real service user abuse/neglect produces staff abuse	1,2,3	I don't think there is any patient who does not come here fearing if anything will go wrong, I guess this must happen in each hospital… it is natural. What happens often between patients and medical staff, doctors primarily is self-explanatory, patients punch doctors as doctors won't serve them unless you 'vote' for them…..I am surprised it did not happen to me here…..abuse, no matter of what kind it is, produces abuse…..(Service user) We treat people to get better not worse with us, let alone the fact that it is scary to think of not treating someone well as their family members may vandalize us, as it has happened and happens still. If you are looking for stats, speak to the chief surgeon, perhaps he has some information on this…(Member of staff)
Limited staff training on service users rights in hand with lack of posted staff rights	1,3	I have not had any training on how to handle crisis situations correctly other than some general information. I think it is needed and we also need some sort of policy or poster on the walls as to what the code of conduct in our unit should be for everyone here (Member of staff)

QualityRights Theme 5: The right to live independently and be included in the community questions were not administered with the Elbasan General Hospital given that these questions did not apply to this setting.

VLORA HOSPITALS WHO QUALITYRIGHTS RATINGS

THEME 1

The right to an adequate standard of living [Article 28 of the Convention on the Rights of Persons with Disabilities (CRPD)]

Overall Scores:

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units): A/P

Standards

1.1 The building is in good physical condition.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units): A/P

1.2 The sleeping conditions of service users are comfortable and allow sufficient privacy.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): A/P

1.3 The facility meets hygiene and sanitary requirements.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units): A/P

1.4 Service users are given food, safe drinking-water and clothing that meet their needs and preferences.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units): A/F

1.5 Service users can communicate freely, and their right to privacy is respected.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): N/I

Vlora Regional Hospital (Inpatient Surgery Units): A/P

1.6 The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units): N/A

1.7 Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): N/A

THEME 1, Standard 1.1

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.1. The building is in good physical condition. (Score this standard after assessing each criterion below.)	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.1.1. The building is in a good state of repair (e.g. windows are not broken, paint is not peeling from the walls).	A/P	A/P
Criterion 1.1.2. The building is accessible for people with physical disabilities.	A/P	A/P
Criterion 1.1.3. The building's lighting (artificial and natural), heating and ventilation provide a comfortable living environment.	A/P	A/P
Criterion 1.1.4. Measures are in place to protect people against injury through fire.	A/I	A/P

THEME 1, Standard 1.2

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.2. The sleeping conditions of service users are comfortable and allow sufficient privacy. (Score this standard after assessing each criterion below.)	A/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.2.1. The sleeping quarters provide sufficient living space per service user and are not overcrowded.	A/I	A/P
Criterion 1.2.2. Men and women as well as children and older persons have separate sleeping quarters.	A/F	A/P
Criterion 1.2.3. Service users are free to choose when to get up and when to go to bed.	A/I	A/F
Criterion 1.2.4. The sleeping quarters allow for the privacy of service users.	A/I	N/I
Criterion 1.2.5. Sufficient numbers of clean blankets and bedding are available to service users.	A/P	A/F
Criterion 1.2.6. Service users can keep personal belongings and have adequate lockable space to store them.	A/I	A/I

THEME 1, Standard 1.3

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.3. The facility meets hygiene and sanitary requirements. (Score this standard after assessing each criterion below.)	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.3.1. The bathing and toilet facilities are clean and working properly.	A/P	A/P
Criterion 1.3.2. The bathing and toilet facilities allow privacy, and are separate for both men and women.	A/P	A/F
Criterion 1.3.3. Service users have regular access to bathing and toilet facilities.	A/P	A/F
Criterion 1.3.4. The bathing and toileting needs of service users who are bedridden or who have impaired mobility or other physical disabilities are accommodated.	A/P	A/I

THEME 1, Standard 1.4

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.4. Service users are given food, safe drinking-water and clothing that meet their needs and preferences. (Score this standard after assessing each criterion below.)	A/P	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.4.1. Food and safe drinking-water are available in sufficient quantities, are of good quality and meet with the service user's cultural preferences and physical health requirements.	A/F	A/F
Criterion 1.4.2. Food is prepared and served under satisfactory conditions, and eating areas are culturally appropriate and reflect the eating arrangements in the community.	A/F	A/F
Criterion 1.4.3. Service users can wear their own clothing and shoes (day wear and night wear).	N/I	A/F
Criterion 1.4.4. When service users do not have their own clothing, good-quality clothing is provided that meets the person's cultural preferences and is suitable for the climate.	A/P	A/F

THEME 1, Standard 1.5

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.5. Service users can communicate freely, and their right to privacy is respected. (Score this standard after assessing each criterion below.)	N/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.5.1. Telephones, letters, e-mails and the Internet are freely available to service users, without censorship.	N/I	N/I
Criterion 1.5.2. Service users' privacy in communications is respected.	N/I	A/I
Criterion 1.5.3. Service users can communicate in the language of their choice, and the facility provides support (e.g. translators) to ensure that the service users can express their needs.	A/F	A/F
Criterion 1.5.4. Service users can receive visitors, choose who they want to see and participate in visits at any reasonable time.	A/P	A/F
Criterion 1.5.5. Service users can move freely around the facility.	N/I	A/P

THEME 1, Standard 1.6

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.6. The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction. (Score this standard after assessing each criterion below.)	A/P	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.6.1. There are ample furnishings, and they are comfortable and in good condition.	A/I	N/A
Criterion 1.6.2. The layout of the facility is conducive to interaction between and among service users, staff and visitors.	A/I	N/A
Criterion 1.6.3. The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities.	A/P	N/A
Criterion 1.6.4. Rooms within the facility are specifically designated as leisure areas for service users.	A/P	N/A

THEME 1, Standard 1.7

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.7. Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.7.1. Service users can interact with other service users, including members of the opposite sex.	A/I	A/F
Criterion 1.7.2. Personal requests, such as to attend weddings or funerals, are facilitated by staff.	A/P	N/A
Criterion 1.7.3. A range of regularly scheduled, organized activities are offered in both the facility and the community that are relevant and age-appropriate.	A/P	N/A
Criterion 1.7.4. Staff provide information to service users about activities in the community and facilitate their access to those activities.	N/I	N/A
Criterion 1.7.5. Staff facilitate service users' access to entertainment outside of the facility, and entertainment from the community is brought into the facility.	A/I	N/A

THEME 2

The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)

Overall Scores:

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): A/P

Standards

2.1 Facilities are available to everyone who requires treatment and support.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/F

Vlora Regional Hospital (Inpatient Surgery Units): ***A/I***

2.2 The facility has skilled staff and provides good-quality mental health services.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): ***A/P***

2.3 Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): ***A/F***

2.4 Psychotropic medication is available, affordable and used appropriately.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units): ***A/F***

2.5 Adequate services are available for general and reproductive health.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units): ***A/P***

THEME 2, Standard 2.1

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.1. Facilities are available to everyone who requires treatment and support. (Score this standard after assessing each criterion below.)	A/F	A/I
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.1.1. No person is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	A/F	A/I
Criterion 2.1.2. Everyone who requests (mental) health treatment receives care in this facility or is referred to another facility where care can be provided.	A/F	A/P
Criterion 2.1.3. No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	A/F	A/I

THEME 2, Standard 2.2

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.2. The facility has skilled staff and provides good-quality mental health services. (Score this standard after assessing each criterion below.)	A/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.2.1. The facility has staff with sufficiently diverse skills to provide counselling, psychosocial rehabilitation, information, education and support to service users and their families, friends or carer, in order to promote independent living and inclusion in the community.	A/I	A/F
Criterion 2.2.2. Staff are knowledgeable about the availability and role of community services and resources to promote independent living and inclusion in the community.	A/I	A/P
Criterion 2.2.3. Service users can consult with a psychiatrist or other specialized mental health staff when they wish to do so.	A/I	A/P
Criterion 2.2.4. Staff in the facility are trained and licensed to prescribe and review psychotropic medication.	A/F	A/F
Criterion 2.2.5. Staff are given training and written information on the rights of persons with mental disabilities and are familiar with international human rights standards, including the CRPD.	A/I	A/I

Criterion 2.2.6. Service users are informed of and have access to mechanisms for expressing their opinions on service provision and improvement.	A/I	A/P

THEME 2, Standard 2.3

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.3 Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community. (Score this standard after assessing each criterion below.)	A/I	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.3.1. Each service user has a comprehensive, individualized recovery plan that includes his or her social, medical, employment and educational goals as well as objectives for recovery.	A/I	A/F
Criterion 2.3.2. Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service user and a staff member.	A/I	A/P
Criterion 2.3.3 As part of their recovery plans, service users are encouraged to develop advance directives[1] which specify the treatment and recovery options they wish to have as well as those that they don't. Advance Directives are to be used if they are unable to communicate their choices at some point in the future.	N/I	N/A

[1] An advance directive is a written document in which a person can specify in advance choices about health care, treatment and recovery options in the event that they are unable to communicate their choices at some point in the future. Advance directives can also include treatment and recovery options that a person *does not* want to have, and as such can help to ensure that they do not receive any intervention against their wishes.

Criterion 2.3.4. Each service user has access to psychosocial programmes for fulfilling the social roles of his or her choice by developing the skills necessary for employment, education or other areas. Skill development is tailored to the person's recovery preferences and may include enhancement of life and self-care skills.	A/I	N/A
Criterion 2.3.5. Service users are encouraged to establish a social support network and/or maintain contact with members of their network to facilitate independent living in the community. The facility provides assistance in connecting service users with family and friends, in line with their wishes.	A/I	N/A
Criterion 2.3.6. Facilities link service users with the general health care system, other levels of mental health services, such as secondary care, and services in the community such as grants, housing, employment agencies, day-care centres and assisted residential care.	A/I	N/A

THEME 2, Standard 2.4

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.4. Psychotropic medication is available, affordable and used appropriately. (Score this standard after assessing each criterion below.)	A/P	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.4.1. The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed.	A/F	A/F
Criterion 2.4.2. A constant supply of essential psychotropic medication is available, in sufficient quantities to meet the needs of service users.	A/F	A/F
Criterion 2.4.3. Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly.	N/A	N/A
Criterion 2.4.4. Service users are informed about the purpose of the medications being offered and any potential side effects.	A/I	A/F
Criterion 2.4.5. Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.	A/I	N/A

THEME 2, Standard 2.5

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.5 Adequate services are available for general and reproductive health. (Score this standard after assessing each criterion below.)	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.5.1. Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter.	A/F	A/F
Criterion 2.5.2. Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral.	A/P	A/P
Criterion 2.5.3. When surgical or medical procedures are needed that cannot be provided at the facility, there are referral mechanisms to ensure that the service users receive these health services in a timely manner.	A/P	A/P
Criterion 2.5.4. Regular health education and promotion are conducted at the facility.	A/P	A/P
Criterion 2.5.5. Service users are informed of and advised about reproductive health and family planning matters.	N/I	A/P
Criterion 2.5.6. General and reproductive health services are provided to service users with free and informed consent.	A/P	A/F

THEME 3

The right to exercise legal capacity, the right to personal liberty and security of person (Articles 12 and 14 of the CPD)

Overall Scores:

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): A/P

Standards

3.1 Service users' preferences on the place and form of treatment are always a priority.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): A/I

3.2 Procedures and safeguards are in place to prevent detention and treatment without free and informed consent.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): A/F

3.3 Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): A/P

3.4 Service users have the right to confidentiality and access to their personal health information.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units: A/P

THEME 3, Standard 3.1

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora General Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.1. Service users' preferences regarding the place and form of treatment are always a priority. (Score this standard after assessing each criterion below.)	A/I	A/I
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.1.1. Service users' preferences are the priority in all decisions on where they will access services.	N/I	N/I
Criterion 3.1.2. All efforts are made to facilitate discharge so that service users can live in their communities.	A/I	A/F
Criterion 3.1.3. Service users' preferences are the priority for all decisions on their treatment and recovery plans.	A/I	A/I

THEME 3, Standard 3.2

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.2. Procedures and safeguards are in place to prevent detention and treatment without free and informed consent. (Score this standard after assessing each criterion below.)	A/I	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.2.1. Admission and treatment are based on the free and informed consent of service users.	A/P	A/F
Criterion 3.2.2. Staff respect the advance directives of service users when providing treatment.	N/I	N/A
Criterion 3.2.3. Service users have the right to refuse treatment	A/I	A/F
Criterion 3.2.4. Any case of treatment or detention in a facility without free and informed consent is documented and reported rapidly to a legal authority.	A/P	N/A
Criterion 3.2.5. People being treated or detained by a facility without their informed consent are informed about procedures for appealing their treatment or detention.	N/I	N/A
Criterion 3.2.6. Facilities support people being treated or detained without their informed consent in accessing appeals procedures and legal representation.	N/I	N/A

THEME 3, Standard 3.3

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.3 Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity. (Score this standard after assessing each criterion below.)	A/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.3.1. At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.	A/P	A/P
Criterion 3.3.2. Clear, comprehensive information about the rights of service users is provided in both written and verbal form.	A/I	A/I
Criterion 3.3.3. Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.	A/I	A/P
Criterion 3.3.4. Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff.	A/I	A/F
Criterion 3.3.5	A/P	A/F

Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported.		
Criterion 3.3.6. Supported decision-making is the predominant model, and substitute decision-making is avoided.	A/I	A/P
Criterion 3.3.7. When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access appropriate support.	N/I	N/A

THEME 3, Standard 3.4

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.4. Service users have the right to confidentiality and access to their personal health information. (Score this standard after assessing each criterion below.)	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.4.1. A personal, confidential medical file is created for each service user.	A/F	A/F
Criterion 3.4.2. Service users have access to the information contained in their medical files.	N/I	N/I
Criterion 3.4.3. Information about service users is kept confidential.	A/F	A/F
Criterion 3.4.4. Service users can add written information, opinions and comments to their medical files without censorship.	N/I	N/I

THEME 4

Freedom from torture or cruel, inhumane or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)

Overall Scores

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units): A/I

Standards

4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units: A/P

4.2 Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/P

Vlora Regional Hospital (Inpatient Surgery Units: A/P

4.3 Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent **or** irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): N/A

Vlora Regional Hospital (Inpatient Surgery Units: N/A

4.4 No service user is subjected to medical or scientific experimentation without his or her informed consent.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): N/A

Vlora Regional Hospital (Inpatient Surgery Units: N/A

4.5 Safeguards are in place to prevent torture or cruel, inhumane or degrading treatment and other forms of ill-treatment and abuse.

‘Ali Mihali’ Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units: A/I

Theme 4, Standard 4.1

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.1. Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect. (Score this standard after assessing each criterion below.)	A/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.1.1. Staff members treat service users with humanity, dignity and respect.	A/P	A/P
Criterion 4.1.2. No service user is subjected to verbal, physical, sexual or mental abuse.	A/I	A/P
Criterion 4.1.3. No service user is subjected to physical or emotional neglect.	A/I	A/I
Criterion 4.1.4. Appropriate steps are taken to prevent all instances of abuse.	A/P	A/P
Criterion 4.1.5. Staff support service users who have been subjected to abuse in accessing the support they may want.	A/I	A/I

THEME 4, Standard 4.2

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.2. Alternative methods are used in place of seclusion[2] and restraint[3] as means of de-escalating potential crises. (Score this standard after assessing each criterion below.	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.2.1. Service users are not subjected to seclusion or restraint.	A/I	A/F
Criterion 4.2.2. Alternatives to seclusion and restraint are in place at the facility, and staff are trained in de-escalation techniques for intervening in crises and preventing harm to service users or staff.	A/P	A/P
Criterion 4.2.3. A de-escalation assessment is conducted in consultation with the service user concerned in order to identify the triggers[4] and factors he or she find helpful in diffusing crises and to determine the preferred methods of intervention in crises.	A/P	N/A
Criterion 4.2.4. The preferred methods of intervention identified by the service user concerned are readily available in a crisis and are integrated into the user's individual recovery plan.	A/I	N/A

1 'Restraint' means the use of a mechanical device or medication to involuntarily prevent a person from moving his or her body.

3 'Seclusion' means the involuntary placement of an individual alone in a locked room or secured area from which he or she is physically prevented from leaving.

3 Triggers might include being pressured to do something, being asked certain questions or being in the presence of a person one is not comfortable with. Factors that help to diffuse a crisis might include being left alone for a while, talking to a person one trusts or listening to music.

Criterion 4.2.5. Any instances of seclusion or restraint are recorded (i.e. type, duration) and reported to the head of the facility and to a relevant external body.	A/P	A/P

THEME 4, Standard 4.3

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.3. Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user. (Score this standard after assessing each criterion below.)	N/A	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.3.1. No electroconvulsive therapy is given without the free and informed consent of service users.	N/A	N/A
Criterion 4.3.2. Clear, evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to.	N/A	N/A
Criterion 4.3.3. Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant).	N/A	N/A
Criterion 4.3.4. No minor is given electroconvulsive therapy.	N/A	N/A
Criterion 4.3.5. Psychosurgery and other irreversible treatments are not conducted without both the service users free and informed consent and the independent approval of a board.	N/A	N/A

Criterion 4.3.6. Abortions and sterilizations are not carried out on service users without their consent.	N/A	N/A

THEME 4, Standard 4.4

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.4. No service user is subjected to medical or scientific experimentation without his or her informed consent. (Score this standard after assessing each criterion below.)	N/A	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.4.1. Medical or scientific experimentation is conducted only with the free and informed consent of service users.	N/A	N/A
Criterion 4.4.2. Staff do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting service users to participate in medical or scientific experimentation.	N/A	N/A
Criterion 4.4.3. Medical or scientific experimentation is not undertaken if it is potentially harmful or dangerous to the service user.	N/A	N/A
Criterion 4.4.4. Any medical or scientific experimentation is approved by an independent ethics committee.	N/A	N/A

THEME 4, Standard 4.5

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.5. Safeguards are in place to prevent torture or cruel, inhumane or degrading treatment and other forms of ill-treatment and abuse. (Score this standard after assessing each criterion below.)	A/I	A/I
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.5.1. Service users are informed of and have access to procedures to file appeals and complaints, on a confidential basis, to an outside, independent legal body on issues related to neglect, abuse, seclusion or restraint, admission or treatment without informed consent and other relevant matters.	A/I	A/I
Criterion 4.5.2. Service users are safe from negative repercussions resulting from complaints they may file.	A/P	A/I
Criterion 4.5.3. Service users have access to legal representatives and can meet with them confidentially.	N/I	N/A
Criterion 4.5.4. Service users have access to advocates to inform them of their rights, discuss problems and support them in exercising their human rights and filing appeals and complaints.	N/I	N/I
Criterion 4.5.5. Disciplinary and/or legal action is taken against any person found to be abusing or neglecting service users.	A/P	A/P

Criterion 4.5.6. The facility is monitored by an independent authority to prevent the occurrence of ill-treatment.	A/P	N/I

THEME 5

The right to live independently and be included in the community (Article 19 of the CPRD)

Overall Scores:

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units: N/A

Standards

5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units: N/A

5.2 Service users can access education and employment opportunities.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units: N/A

5.3 The right of service users to participate in political and public life and to exercise freedom of association is supported.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): N/I

Vlora Regional Hospital (Inpatient Surgery Units: N/A

5.4 Service users are supported in taking part in social, cultural, religious and leisure activities.

'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units): A/I

Vlora Regional Hospital (Inpatient Surgery Units: N/A

THEME 5, Standard 5.1

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.1. Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.1.1. Staff inform service users about options for housing and financial resources.	A/I	N/A
Criterion 5.1.2. Staff support service users in accessing and maintaining safe, affordable, decent housing.	A/I	N/A
Criterion 5.1.3. Staff support service users in accessing the financial resources necessary to live in the community.	A/I	N/A

THEME 5, Standard 5.2

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.2. Service users can access education and employment opportunities. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.2.1. Staff give service users information about education and employment opportunities in the community.	A/I	N/A
Criterion 5.2.2. Staff support service users in accessing education opportunities, including primary, secondary and post-secondary education.	N/I	N/A
Criterion 5.2.3. Staff support service users in career development and in accessing paid employment opportunities.	A/P	N/A

THEME 5, Standard 5.3

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.3. The right of service users to participate in political and public life and to exercise freedom of association is supported. (Score this standard after assessing each criterion below.)	N/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.3.1. Staff give service users the information necessary for them to participate fully in political and public life and to enjoy the benefits of freedom of association.	N/I	N/A
Criterion 5.3.2. Staff support service users in exercising their right to vote.	A/I	N/A
Criterion 5.3.3. Staff support service users in joining and participating in the activities of political, religious, social, disability and mental disability organizations and other groups.	N/I	N/A

THEME 5, Standard 5.4

	'Ali Mihali' Vlora Psychiatric Hospital (Inpatient Units)	Vlora Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.4. Service users are supported in taking part in social, cultural, religious and leisure activities. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.4.1. Staff give service users information on the social, cultural, religious and leisure activity options available.	A/I	N/A
Criterion 5.4.2. Staff support service users in participating in the social and leisure activities of their choice.	A/I	N/A
Criterion 5.4.3. Staff support service users in participating in the cultural and religious activities of their choice.	A/P	N/A

ELBASAN HOSPITALS WHO QUALITY RIGHTS RATINGS

THEME 1

The right to an adequate standard of living [Article 28 of the Convention on the Rights of Persons with Disabilities (CRPD)]

Overall Scores:

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

Standards

1.1 The building is in good physical condition.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): N/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

1.2 The sleeping conditions of service users are comfortable and allow sufficient privacy.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): N/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

1.3 The facility meets hygiene and sanitary requirements.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/F

1.4 Service users are given food, safe drinking-water and clothing that meet their needs and preferences.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/P

Elbasan Regional Hospital (Inpatient Surgery Unit): A/F

1.5 Service users can communicate freely, and their right to privacy is respected.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): N/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

1.6 The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): N/A

1.7 Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): N/A

THEME 1, Standard 1.1

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.1. The building is in good physical condition. (Score this standard after assessing each criterion below.)	N/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.1.1. The building is in a good state of repair (e.g. windows are not broken, paint is not peeling from the walls).	A/I	A/P
Criterion 1.1.2. The building is accessible for people with physical disabilities.	N/I	A/P
Criterion 1.1.3. The building's lighting (artificial and natural), heating and ventilation provide a comfortable living environment.	N/I	A/P
Criterion 1.1.4. Measures are in place to protect people against injury through fire.	N/I	A/P

THEME 1, Standard 1.2

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.2. The sleeping conditions of service users are comfortable and allow sufficient privacy. (Score this standard after assessing each criterion below.)	N/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.2.1. The sleeping quarters provide sufficient living space per service user and are not overcrowded.	N/I	A/P
Criterion 1.2.2. Men and women as well as children and older persons have separate sleeping quarters.	A/F	A/P
Criterion 1.2.3. Service users are free to choose when to get up and when to go to bed.	N/I	A/F
Criterion 1.2.4. The sleeping quarters allow for the privacy of service users.	N/I	N/I
Criterion 1.2.5. Sufficient numbers of clean blankets and bedding are available to service users.	A/I	A/F
Criterion 1.2.6. Service users can keep personal belongings and have adequate lockable space to store them.	N/I	A/P

THEME 1, Standard 1.3

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.3. The facility meets hygiene and sanitary requirements. (Score this standard after assessing each criterion below.)	A/I	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.3.1. The bathing and toilet facilities are clean and working properly.	A/I	A/F
Criterion 1.3.2. The bathing and toilet facilities allow privacy, and are separate for both men and women.	A/I	A/F
Criterion 1.3.3. Service users have regular access to bathing and toilet facilities.	A/I	A/F
Criterion 1.3.4. The bathing and toileting needs of service users who are bedridden or who have impaired mobility or other physical disabilities are accommodated.	A/P	A/P

THEME 1, Standard 1.4

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.4. Service users are given food, safe drinking-water and clothing that meet their needs and preferences. (Score this standard after assessing each criterion below.)	A/P	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.4.1. Food and safe drinking-water are available in sufficient quantities, are of good quality and meet with the service user's cultural preferences and physical health requirements.	A/F	A/F
Criterion 1.4.2. Food is prepared and served under satisfactory conditions, and eating areas are culturally appropriate and reflect the eating arrangements in the community.	A/F	A/F
Criterion 1.4.3. Service users can wear their own clothing and shoes (day wear and night wear).	N/I	A/F
Criterion 1.4.4. When service users do not have their own clothing, good-quality clothing is provided that meets the person's cultural preferences and is suitable for the climate.	A/P	A/F

THEME 1, Standard 1.5

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.5. Service users can communicate freely, and their right to privacy is respected. (Score this standard after assessing each criterion below.)	N/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.5.1. Telephones, letters, e-mails and the Internet are freely available to service users, without censorship.	N/I	N/I
Criterion 1.5.2. Service users' privacy in communications is respected.	N/I	A/I
Criterion 1.5.3. Service users can communicate in the language of their choice, and the facility provides support (e.g. translators) to ensure that the service users can express their needs.	A/F	A/F
Criterion 1.5.4. Service users can receive visitors, choose who they want to see and participate in visits at any reasonable time.	A/P	A/F
Criterion 1.5.5. Service users can move freely around the facility.	N/I	A/P

THEME 1, Standard 1.6

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.6. The facility provides a welcoming, comfortable, stimulating environment conducive to active participation and interaction. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.6.1. There are ample furnishings, and they are comfortable and in good condition.	A/I	N/A
Criterion 1.6.2. The layout of the facility is conducive to interaction between and among service users, staff and visitors.	A/I	N/A
Criterion 1.6.3. The necessary resources, including equipment, are provided by the facility to ensure that service users have opportunities to interact and participate in leisure activities.	A/I	N/A
Criterion 1.6.4. Rooms within the facility are specifically designated as leisure areas for service users.	A/P	N/A

THEME 1, Standard 1.7

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 1.7. Service users can enjoy fulfilling social and personal lives and remain engaged in community life and activities. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 1.7.1. Service users can interact with other service users, including members of the opposite sex.	A/I	N/A
Criterion 1.7.2. Personal requests, such as to attend weddings or funerals, are facilitated by staff.	A/P	N/A
Criterion 1.7.3. A range of regularly scheduled, organized activities are offered in both the facility and the community that are relevant and age-appropriate.	A/P	N/A
Criterion 1.7.4. Staff provide information to service users about activities in the community and facilitate their access to those activities.	N/I	N/A
Criterion 1.7.5. Staff facilitate service users' access to entertainment outside of the facility, and entertainment from the community is brought into the facility.	A/I	N/A

THEME 2

The right to enjoyment of the highest attainable standard of physical and mental health (Article 25 of the CRPD)

Overall Scores:

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

Standards

2.1 Facilities are available to everyone who requires treatment and support.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/F

Elbasan Regional Hospital (Inpatient Surgery Unit): ***A/P***

2.2 The facility has skilled staff and provides good-quality mental health services.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): ***A/P***

2.3 Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): ***A/F***

2.4 Psychotropic medication is available, affordable and used appropriately.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/P

Elbasan Regional Hospital (Inpatient Surgery Unit): ***A/I***

2.5 Adequate services are available for general and reproductive health.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): ***A/F***

THEME 2, Standard 2.1

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.1. Facilities are available to everyone who requires treatment and support. (Score this standard after assessing each criterion below.)	A/F	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.1.1. No person is denied access to facilities or treatment on the basis of economic factors or of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	A/F	A/F
Criterion 2.1.2. Everyone who requests (mental) health treatment receives care in this facility or is referred to another facility where care can be provided.	A/F	A/I
Criterion 2.1.3. No service user is admitted, treated or kept in the facility on the basis of his or her race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, disability, birth, age or other status.	A/F	A/F

THEME 2, Standard 2.2

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.2. The facility has skilled staff and provides good-quality mental health services. (Score this standard after assessing each criterion below.)	A/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.2.1. The facility has staff with sufficiently diverse skills to provide counselling, psychosocial rehabilitation, information, education and support to service users and their families, friends or carer, in order to promote independent living and inclusion in the community.	A/I	A/F
Criterion 2.2.2. Staff are knowledgeable about the availability and role of community services and resources to promote independent living and inclusion in the community.	A/I	A/P
Criterion 2.2.3. Service users can consult with a psychiatrist or other specialized mental health staff when they wish to do so.	A/I	A/P
Criterion 2.2.4. Staff in the facility are trained and licensed to prescribe and review psychotropic medication.	A/F	A/F
Criterion 2.2.5. Staff are given training and written information on the rights of persons with mental disabilities and are familiar with international human rights standards, including the CRPD.	A/I	A/I

Criterion 2.2.6. Service users are informed of and have access to mechanisms for expressing their opinions on service provision and improvement.	A/I	A/P

THEME 2, Standard 2.3

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.3 Treatment, psychosocial rehabilitation and links to support networks and other services are elements of a service user-driven recovery plan and contribute to a service user's ability to live independently in the community. (Score this standard after assessing each criterion below.)	A/I	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.3.1. Each service user has a comprehensive, individualized recovery plan that includes his or her social, medical, employment and educational goals as well as objectives for recovery.	A/I	A/F
Criterion 2.3.2. Recovery plans are driven by the service user, reflect his or her choices and preferences for care, are put into effect and are reviewed and updated regularly by the service user and a staff member.	A/I	A/P
Criterion 2.3.3 As part of their recovery plans, service users are encouraged to develop advance directives[1] which specify the treatment and recovery options they wish to have as well as those that they don't. Advance Directives are to be used if they are unable to communicate their choices at some point in the future.	N/I	N/A

[1] An advance directive is a written document in which a person can specify in advance choices about health care, treatment and recovery options in the event that they are unable to communicate their choices at some point in the future. Advance directives can also include treatment and recovery options that a person *does not* want to have, and as such can help to ensure that they do not receive any intervention against their wishes.

Criterion 2.3.4. Each service user has access to psychosocial programmes for fulfilling the social roles of his or her choice by developing the skills necessary for employment, education or other areas. Skill development is tailored to the person's recovery preferences and may include enhancement of life and self-care skills.	A/I	N/A
Criterion 2.3.5. Service users are encouraged to establish a social support network and/or maintain contact with members of their network to facilitate independent living in the community. The facility provides assistance in connecting service users with family and friends, in line with their wishes.	A/I	N/A
Criterion 2.3.6. Facilities link service users with the general health care system, other levels of mental health services, such as secondary care, and services in the community such as grants, housing, employment agencies, day-care centres and assisted residential care.	A/I	N/A

THEME 2, Standard 2.4

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.4. Psychotropic medication is available, affordable and used appropriately. (Score this standard after assessing each criterion below.)	A/P	A/I
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.4.1. The appropriate psychotropic medication (specified in the national essential medicines list) is available at the facility or can be prescribed.	A/F	A/I
Criterion 2.4.2. A constant supply of essential psychotropic medication is available, in sufficient quantities to meet the needs of service users.	A/F	A/I
Criterion 2.4.3. Medication type and dosage are always appropriate for the clinical diagnoses of service users and are reviewed regularly.	N/A	N/A
Criterion 2.4.4. Service users are informed about the purpose of the medications being offered and any potential side effects.	A/I	A/F
Criterion 2.4.5. Service users are informed about treatment options that are possible alternatives to or could complement medication, such as psychotherapy.	A/I	N/A

THEME 2, Standard 2.5

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 2.5 Adequate services are available for general and reproductive health. (Score this standard after assessing each criterion below.)	A/I	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 2.5.1. Service users are offered physical health examinations and/or screening for particular illnesses on entry to the facility and regularly thereafter.	A/I	A/F
Criterion 2.5.2. Treatment for general health problems, including vaccinations, is available to service users at the facility or by referral.	A/P	A/F
Criterion 2.5.3. When surgical or medical procedures are needed that cannot be provided at the facility, there are referral mechanisms to ensure that the service users receive these health services in a timely manner.	A/P	A/P
Criterion 2.5.4. Regular health education and promotion are conducted at the facility.	A/I	A/F
Criterion 2.5.5. Service users are informed of and advised about reproductive health and family planning matters.	N/I	A/P
Criterion 2.5.6. General and reproductive health services are provided to service users with free and informed consent.	A/P	A/F

THEME 3

The right to exercise legal capacity, the right to personal liberty and security of person (Articles 12 and 14 of the CPD)

Overall Scores:

'Sadik Dinci' Elbasan Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

Standards

3.1 Service users' preferences on the place and form of treatment are always a priority.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/I

3.2 Procedures and safeguards are in place to prevent detention and treatment without free and informed consent.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/F

3.3 Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

3.4 Service users have the right to confidentiality and access to their personal health information.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/P

Elbasan Regional Hospital (Inpatient Surgery Unit: A/P

THEME 3, Standard 3.1

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan General Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.1. Service users' preferences regarding the place and form of treatment are always a priority. (Score this standard after assessing each criterion below.)	A/I	A/I
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.1.1. Service users' preferences are the priority in all decisions on where they will access services.	N/I	A/I
Criterion 3.1.2. All efforts are made to facilitate discharge so that service users can live in their communities.	A/I	A/F
Criterion 3.1.3. Service users' preferences are the priority for all decisions on their treatment and recovery plans.	A/I	A/I

THEME 3, Standard 3.2

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.2. Procedures and safeguards are in place to prevent detention and treatment without free and informed consent. (Score this standard after assessing each criterion below.)	A/I	A/F
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.2.1. Admission and treatment are based on the free and informed consent of service users.	A/P	A/F
Criterion 3.2.2. Staff respect the advance directives of service users when providing treatment.	N/I	N/A
Criterion 3.2.3. Service users have the right to refuse treatment	A/I	A/F
Criterion 3.2.4. Any case of treatment or detention in a facility without free and informed consent is documented and reported rapidly to a legal authority.	A/P	N/A
Criterion 3.2.5. People being treated or detained by a facility without their informed consent are informed about procedures for appealing their treatment or detention.	N/I	N/A
Criterion 3.2.6. Facilities support people being treated or detained without their informed consent in accessing appeals procedures and legal representation.	N/I	N/A

THEME 3, Standard 3.3

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.3 Service users can exercise their legal capacity and are given the support they may require to exercise their legal capacity. (Score this standard after assessing each criterion below.)	A/I	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.3.1. At all times, staff interact with service users in a respectful way, recognizing their capacity to understand information and make decisions and choices.	A/P	A/P
Criterion 3.3.2. Clear, comprehensive information about the rights of service users is provided in both written and verbal form.	A/I	A/P
Criterion 3.3.3. Clear, comprehensive information about assessment, diagnosis, treatment and recovery options is given to service users in a form that they understand and which allows them to make free and informed decisions.	A/I	A/P
Criterion 3.3.4. Service users can nominate and consult with a support person or network of people of their own free choice in making decisions about admission, treatment and personal, legal, financial or other affairs, and the people selected will be recognized by the staff.	A/I	A/F
Criterion 3.3.5	A/P	A/F

Staff respect the authority of a nominated support person or network of people to communicate the decisions of the service user being supported.		
Criterion 3.3.6. Supported decision-making is the predominant model, and substitute decision-making is avoided.	N/I	A/P
Criterion 3.3.7. When a service user has no support person or network of people and wishes to appoint one, the facility will help the user to access appropriate support.	N/I	N/A

THEME 3, Standard 3.4

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 3.4. Service users have the right to confidentiality and access to their personal health information. (Score this standard after assessing each criterion below.)	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 3.4.1. A personal, confidential medical file is created for each service user.	A/F	A/F
Criterion 3.4.2. Service users have access to the information contained in their medical files.	N/I	N/I
Criterion 3.4.3. Information about service users is kept confidential.	A/F	A/F
Criterion 3.4.4. Service users can add written information, opinions and comments to their medical files without censorship.	N/I	N/I

THEME 4

Freedom from torture or cruel, inhumane or degrading treatment or punishment and from exploitation, violence and abuse (Articles 15 and 16 of the CRPD)

Overall Scores

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/P

Elbasan Regional Hospital (Inpatient Surgery Unit): A/P

Standards

4.1 Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/P

Elbasan Regional Hospital (Inpatient Surgery Unit: A/P

4.2 Alternative methods are used in place of seclusion and restraint as means of de-escalating potential crises.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/P

Elbasan Regional Hospital (Inpatient Surgery Unit: A/P

4.3 Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent **or** irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): N/A

Elbasan Regional Hospital (Inpatient Surgery Unit: N/A

4.4 No service user is subjected to medical or scientific experimentation without his or her informed consent.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): N/A

Elbasan Regional Hospital (Inpatient Surgery Unit: N/A

4.5 Safeguards are in place to prevent torture or cruel, inhumane or degrading treatment and other forms of ill-treatment and abuse.

‘Sadik Dinci’ Elbasan Psychiatric Hospital (Inpatient Units): A/P

Elbasan Regional Hospital (Inpatient Surgery Unit: A/I

Theme 4, Standard 4.1

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.1. Service users have the right to be free from verbal, mental, physical and sexual abuse and physical and emotional neglect. (Score this standard after assessing each criterion below.)	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.1.1. Staff members treat service users with humanity, dignity and respect.	A/P	A/P
Criterion 4.1.2. No service user is subjected to verbal, physical, sexual or mental abuse.	A/P	A/F
Criterion 4.1.3. No service user is subjected to physical or emotional neglect.	A/P	A/P
Criterion 4.1.4. Appropriate steps are taken to prevent all instances of abuse.	A/P	A/P
Criterion 4.1.5. Staff support service users who have been subjected to abuse in accessing the support they may want.	A/P	A/I

THEME 4, Standard 4.2

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.2. Alternative methods are used in place of seclusion[2] and restraint[3] as means of de-escalating potential crises. (Score this standard after assessing each criterion below.	A/P	A/P
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.2.1. Service users are not subjected to seclusion or restraint.	A/I	A/F
Criterion 4.2.2. Alternatives to seclusion and restraint are in place at the facility, and staff are trained in de-escalation techniques for intervening in crises and preventing harm to service users or staff.	A/P	A/P
Criterion 4.2.3. A de-escalation assessment is conducted in consultation with the service user concerned in order to identify the triggers[4] and factors he or she find helpful in diffusing crises and to determine the preferred methods of intervention in crises.	A/P	A/I
Criterion 4.2.4. The preferred methods of intervention identified by the service user concerned are readily available in a crisis and are integrated into the user's individual recovery plan.	A/I	N/A

1 'Restraint' means the use of a mechanical device or medication to involuntarily prevent a person from moving his or her body.

3 'Seclusion' means the involuntary placement of an individual alone in a locked room or secured area from which he or she is physically prevented from leaving.

3 Triggers might include being pressured to do something, being asked certain questions or being in the presence of a person one is not comfortable with. Factors that help to diffuse a crisis might include being left alone for a while, talking to a person one trusts or listening to music.

Criterion 4.2.5. Any instances of seclusion or restraint are recorded (i.e. type, duration) and reported to the head of the facility and to a relevant external body.	A/P	A/P

THEME 4, Standard 4.3

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.3. Electroconvulsive therapy, psychosurgery and other medical procedures that may have permanent or irreversible effects, whether performed at the facility or referred to another facility, must not be abused and can be administered only with the free and informed consent of the service user. (Score this standard after assessing each criterion below.)	N/A	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.3.1. No electroconvulsive therapy is given without the free and informed consent of service users.	N/A	N/A
Criterion 4.3.2. Clear, evidence-based clinical guidelines on when and how electroconvulsive therapy can or cannot be administered are available and adhered to.	N/A	N/A
Criterion 4.3.3. Electroconvulsive therapy is never used in its unmodified form (i.e. without an anaesthetic and a muscle relaxant).	N/A	N/A
Criterion 4.3.4. No minor is given electroconvulsive therapy.	N/A	N/A
Criterion 4.3.5. Psychosurgery and other irreversible treatments are not conducted without both the service users free and informed consent and the independent approval of a board.	N/A	N/A

Criterion 4.3.6. Abortions and sterilizations are not carried out on service users without their consent.	N/A	N/A

THEME 4, Standard 4.4

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.4. No service user is subjected to medical or scientific experimentation without his or her informed consent. (Score this standard after assessing each criterion below.)	N/A	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.4.1. Medical or scientific experimentation is conducted only with the free and informed consent of service users.	N/A	N/A
Criterion 4.4.2. Staff do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting service users to participate in medical or scientific experimentation.	N/A	N/A
Criterion 4.4.3. Medical or scientific experimentation is not undertaken if it is potentially harmful or dangerous to the service user.	N/A	N/A
Criterion 4.4.4. Any medical or scientific experimentation is approved by an independent ethics committee.	N/A	N/A

THEME 4, Standard 4.5

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 4.5. Safeguards are in place to prevent torture or cruel, inhumane or degrading treatment and other forms of ill-treatment and abuse. (Score this standard after assessing each criterion below.)	A/P	A/I
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 4.5.1. Service users are informed of and have access to procedures to file appeals and complaints, on a confidential basis, to an outside, independent legal body on issues related to neglect, abuse, seclusion or restraint, admission or treatment without informed consent and other relevant matters.	A/I	A/I
Criterion 4.5.2. Service users are safe from negative repercussions resulting from complaints they may file.	A/P	A/P
Criterion 4.5.3. Service users have access to legal representatives and can meet with them confidentially.	N/I	N/A
Criterion 4.5.4. Service users have access to advocates to inform them of their rights, discuss problems and support them in exercising their human rights and filing appeals and complaints.	N/I	N/I
Criterion 4.5.5. Disciplinary and/or legal action is taken against any person found to be abusing or neglecting service users.	A/F	A/P

Criterion 4.5.6. The facility is monitored by an independent authority to prevent the occurrence of ill-treatment.	A/P	N/I

THEME 5

The right to live independently and be included in the community (Article 19 of the CPRD)

Overall Scores:

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit): N/A

Standards

5.1 Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit: N/A

5.2 Service users can access education and employment opportunities.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit: N/A

5.3 The right of service users to participate in political and public life and to exercise freedom of association is supported.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): N/I

Elbasan Regional Hospital (Inpatient Surgery Unit: N/A

5.4 Service users are supported in taking part in social, cultural, religious and leisure activities.

'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units): A/I

Elbasan Regional Hospital (Inpatient Surgery Unit: N/A

THEME 5, Standard 5.1

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.1. Service users are supported in gaining access to a place to live and have the financial resources necessary to live in the community. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.1.1. Staff inform service users about options for housing and financial resources.	A/I	N/A
Criterion 5.1.2. Staff support service users in accessing and maintaining safe, affordable, decent housing.	A/I	N/A
Criterion 5.1.3. Staff support service users in accessing the financial resources necessary to live in the community.	A/I	N/A

THEME 5, Standard 5.2

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.2. Service users can access education and employment opportunities. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.2.1. Staff give service users information about education and employment opportunities in the community.	A/I	N/A
Criterion 5.2.2. Staff support service users in accessing education opportunities, including primary, secondary and post-secondary education.	N/I	N/A
Criterion 5.2.3. Staff support service users in career development and in accessing paid employment opportunities.	A/I	N/A

THEME 5, Standard 5.3

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.3. The right of service users to participate in political and public life and to exercise freedom of association is supported. (Score this standard after assessing each criterion below.)	N/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.3.1. Staff give service users the information necessary for them to participate fully in political and public life and to enjoy the benefits of freedom of association.	N/I	N/A
Criterion 5.3.2. Staff support service users in exercising their right to vote.	N/I	N/A
Criterion 5.3.3. Staff support service users in joining and participating in the activities of political, religious, social, disability and mental disability organizations and other groups.	N/I	N/A

THEME 5, Standard 5.4

	'Sadik Dinci' Elbasan Psychiatric Hospital (Inpatient Units)	Elbasan Regional Hospital (Inpatient Surgery Unit)
	Score	Score
Standard 5.4. Service users are supported in taking part in social, cultural, religious and leisure activities. (Score this standard after assessing each criterion below.)	A/I	N/A
CRITERIA AND ACTIONS REQUIRED TO ACHIEVE THIS STANDARD		
Criterion 5.4.1. Staff give service users information on the social, cultural, religious and leisure activity options available.	A/I	N/A
Criterion 5.4.2. Staff support service users in participating in the social and leisure activities of their choice.	A/I	N/A
Criterion 5.4.3. Staff support service users in participating in the cultural and religious activities of their choice.	A/I	N/A